

NAME		TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
***** FI Inpatient/Skilled Nursing Facility (SNF) Claim Record - Encrypted Standard View		REC	VAR			Fiscal intermediary Inpatient/SNF Encrypted Standard View for version I of the NCH.  The Encrypted Standard View supports the users of CMS data and provides the data in "text" ready format for easy conversion to ASCII text files. This file is also specifically processed to perform CMS standard encryption processes for identifiable and personal health information data fields.
***** FI Inpatient/SNF Claim Fixed Group - Encrypted Standard View		GROUP	511	1	511	Fixed portion of the fiscal intermediary claim record for the Encrypted Standard View of the Inpatient/Skilled Nursing Facility version I NCH Nearline File.
1. Record Length Count		NUM	5	1	5	The length of the record.  5 DIGITS UNSIGNED
2. Record Number		NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim.
3. Record Type		NUM	2	15	16	Type of Record.  CODES: 00 = Fixed/Main Group 01 = Carrier Line Group 02 = Claim Demonstration ID Group 03 = Claim Diagnosis Group 04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group 10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number		NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim.
5. NCH Claim Type Code		CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH.  NOTE1: During the Version H conversion this field was populated with data through-out history (back to

service year 1991).

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					NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.
					DB2 ALIAS: NCH_CLM_TYPE_CD SAS ALIAS: CLM_TYPE STANDARD ALIAS: UTLIPSNI_NCH_CLM_TYPE_CD SYSTEM ALIAS: LTTYPE TITLE ALIAS: CLAIM_TYPE
					DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM
					INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT
					INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM
					INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD
					NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.
					PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM
					OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE  
DERIVED FROM: (AVAILABLE IN NMUD)  
FI\_NUM

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					CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD
					DERIVATION RULES:
					SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U' 2. PMT_EDIT_RIC_CD EQUAL 'F' 3. CLM_TRANS_CD EQUAL '5'
					SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '0' OR '4' 4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y' OR 'Z'
					SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '0' OR '4' 4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y' OR 'Z'
					SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'W' 2. PMT_EDIT_RIC_CD EQUAL 'D' 3. CLM_TRANS_CD EQUAL '6'
					SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'W' 2. PMT_EDIT_RIC_CD EQUAL 'D' 3. CLM_TRANS_CD EQUAL '6' 4. FI_NUM = 80881
					SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED' ENCOUNTER CLAIMS -- AVAILABLE IN NMUD) 1. FI_NUM = 80881 2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_ CLSFCTN_TYPE_CD = '2', '3' OR '4' &

CLM\_FREQ\_CD = 'Z', 'Y' OR 'X'

SET CLM\_TYPE\_CD TO 50 (HOSPICE CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'I'
3. CLM\_TRANS\_CD EQUAL 'H'

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					SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
					SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 - 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_MCO_PD_SW = '1' 2. CLM_RLT_COND_CD = '04' 3. MCO_CNTRCT_NUM MCO_OPTN_CD = 'C' CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT ENROLLMENT PERIODS
					SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '1' '2' OR '3' 4. FI_NUM = 80881
					SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. FI_NUM = 80881 AND 2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_ TYPE_CD = '1'; CLM_FREQ_CD = 'Z'
					SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD not on DMEPOS table
					SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

					SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CARR_NUM = 80882 AND 2. CLM_DEMO_ID_NUM = 38
					SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
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					1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD not on DMEPOS table
					SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).
					CODES: REFER TO: NCH_CLM_TYPE_TB IN THE CODES APPENDIX
					SOURCE: NCH
6. Beneficiary Birth Date		NUM	8	22 29	The beneficiary's date of birth.
					For the ENCRYPTED Standard View of the Inpatient/SNF files, the beneficiary's date of birth is coded as a range.
					8 DIGITS UNSIGNED
					DB2 ALIAS: BENE_BIRTH_DT SAS ALIAS: BENE_DOB STANDARD ALIAS: BENE_BIRTH_DT TITLE ALIAS: BENE_BIRTH_DATE
					EDIT-RULES FOR ENCRYPTED DATA: 0000000R WHERE R HAS ONE OF THE FOLLOWING VALUES. 0 = Unknown 1 = <65 2 = 65 Thru 69 3 = 70 Thru 74 4 = 75 Thru 79 5 = 80 Thru 84 6 = >84
					SOURCE:

					CWF		
7.	Beneficiary Identification Code	CHAR	2	30	31	The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.  COMMON ALIAS: BIC DA3 ALIAS: BENE_IDENT_CODE DB2 ALIAS: BENE_IDENT_CD SAS ALIAS: BIC STANDARD ALIAS: BENE_IDENT_CD TITLE ALIAS: BIC	
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						EDIT-RULES: EDB REQUIRED FIELD  CODES: REFER TO: BENE_IDENT_TB IN THE CODES APPENDIX  SOURCE: SSA/RRB	
8.	Beneficiary LRD Used Count	CHAR	4	32	35	The number of lifetime reserve days that the beneficiary has elected to use during the period covered by the institutional claim. Under Medicare, each beneficiary has a one-time reserve of sixty additional days of inpatient hospital coverage that can be used after 90 days of inpatient care have been provided in a single benefit period. This count is used to subtract from the total number of lifetime reserve days that a beneficiary has available.  3 DIGITS SIGNED  DB2 ALIAS: BENE_LRD_USE_CNT SAS ALIAS: LRD_USE STANDARD ALIAS: BENE_LRD_USE_CNT TITLE ALIAS: LRD_USED  EDIT-RULES: +999  SOURCE: CWF	
9.	Beneficiary Race Code	CHAR	1	36	36	The race of a beneficiary.  DA3 ALIAS: RACE_CODE DB2 ALIAS: BENE_RACE_CD SAS ALIAS: RACE	

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CODES:
0 = Unknown
1 = White
2 = Black
3 = Other
4 = Asian
5 = Hispanic
6 = North American Native
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10. Beneficiary Residence SSA Standard County Code	CHAR	3	37	39	<p>The SSA standard county code of a beneficiary's residence.</p> <p>DA3 ALIAS: SSA_STANDARD_COUNTY_CODE  DB2 ALIAS: BENE_SSA_CNTY_CD  SAS ALIAS: CNTY_CD  STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD  TITLE ALIAS: BENE_COUNTY_CD</p> <p>EDIT-RULES:  OPTIONAL: MAY BE BLANK</p> <p>SOURCE:  SSA/EDB</p>
11. Beneficiary Residence SSA Standard State Code	CHAR	2	40	41	<p>The SSA standard state code of a beneficiary's residence.</p> <p>DA3 ALIAS: SSA_STANDARD_STATE_CODE  DB2 ALIAS: BENE_SSA_STATE_CD  SAS ALIAS: STATE_CD  STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD  TITLE ALIAS: BENE_STATE_CD</p> <p>EDIT-RULES:  OPTIONAL: MAY BE BLANK</p> <p>CODES:  REFER TO: GEO_SSA_STATE_TB  IN THE CODES APPENDIX</p> <p>COMMENT:  1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.  2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary</p>

will receive a bill in English or Spanish.  
3. Also used for special studies.

SOURCE:  
SSA/EDB

12. Beneficiary Sex Identification Code CHAR 1 42 42 The sex of a beneficiary.  
  
COMMON ALIAS: SEX\_CD  
DA3 ALIAS: SEX\_CODE  
DB2 ALIAS: BENE\_SEX\_IDENT\_CD  
SAS ALIAS: SEX  
STANDARD ALIAS: BENE\_SEX\_IDENT\_CD  
SYSTEM ALIAS: LTSEX  
TITLE ALIAS: SEX\_CD

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EDIT-RULES:  
REQUIRED FIELD

CODES:  
1 = Male  
2 = Female  
0 = Unknown

SOURCE:  
SSA,RRB,EDB

13. Beneficiary Total Coinsurance Days Count CHAR 4 43 46 The count of the total number of coinsurance days involved with the beneficiary's stay in a facility.  
  
3 DIGITS SIGNED  
  
DB2 ALIAS: COINSRNC\_DAY\_CNT  
SAS ALIAS: COIN\_DAY  
STANDARD ALIAS: BENE\_TOT\_COINSRNC\_DAY\_CNT  
TITLE ALIAS: COINSRNC\_DAYS

EDIT-RULES:  
+999

SOURCE:  
CWF

14. Claim Admission Date NUM 8 47 54 On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or christian science sanitorium.  
  
For the ENCRYPTED Standard View of the Inpatient/SNF files, the admission date for the claim is coded as the quarter of the calendar year when the admission

occurred.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM\_ADMSN\_DT  
SAS ALIAS: ADMSN\_DT  
STANDARD ALIAS: CLM\_ADMSN\_DT  
TITLE ALIAS: ADMISSION\_DT

EDIT-RULES FOR ENCRYPTED DATA:  
YYYYQ000 WHERE Q IS ONE OF THE  
FOLLOWING VALUES.  
1 = FIRST QUARTER OF THE CALENDAR YEAR  
2 = SECOND QUARTER OF THE CALENDAR YEAR  
3 = THIRD QUARTER OF THE CALENDAR YEAR  
4 = FOURTH QUARTER OF THE CALENDAR YEAR

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						SOURCE: CWF
15. Claim Admitting Diagnosis Code		CHAR	5	55	59	An ICD-9-CM code on the institutional inpatient/ SNF claim indicating the beneficiary's initial diagnosis at admission.
						DB2 ALIAS: CLM_ADMTG_DGNS_CD SAS ALIAS: AD_DGNS STANDARD ALIAS: CLM_ADMTG_DGNS_CD TITLE ALIAS: ADMITTING_DIAGNOSIS
						SOURCE: CWF
16. Claim Attending Physician UPIN Number		CHAR	6	60	65	On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).
						This field is ENCRYPTED for the ENCRYPTED Standard View of the Inpatient/SNF files.
						COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN DB2 ALIAS: ATNDG_UPIN SAS ALIAS: AT_UPIN STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM TITLE ALIAS: ATTENDING_PHYSICIAN
						COMMENT: Prior to Version H this field was named: CLM_PRMRY_CARE_PHYSN_IDENT_NUM and contained

10 positions (6-position UPIN and 4-position physician surname).

SOURCE:  
CWF

17. Claim Diagnosis E Code            CHAR            5        66    70 Effective with Version H, the ICD-9-CM code used to identify the external cause of injury, poisoning, or other adverse affect. Redundantly this field is also stored as the last occurrence of the diagnosis trailer.

NOTE: During the Version H conversion, the data in the last occurrence of the diagnosis trailer was used to populate history.

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						DB2 ALIAS: CLM_DGNS_E_CD SAS ALIAS: DGNS_E STANDARD ALIAS: CLM_DGNS_E_CD TITLE ALIAS: DGNS_E_CD  SOURCE: CWF
18. Claim Diagnosis Related Group Code		CHAR	3	71	73	The diagnostic related group to which a hospital claim belongs for prospective payment purposes.  COMMON ALIAS: DRG DB2 ALIAS: CLM_DRG_CD SAS ALIAS: DRG_CD STANDARD ALIAS: CLM_DRG_CD TITLE ALIAS: DRG  EDIT-RULES: DRG DEFINITIONS MANUAL  COMMENT: GROUPER is the software that determines the DRG from data elements reported by the hospital. Once determined, the DRG code is one of the elements used to determine the price upon which to base the reimbursement to the hospitals under prospective payment. Nonpayment claims (zero reimbursement) may not have a DRG present.  SOURCE: CWF
19. Claim Diagnosis Related Group Outlier Stay Code		CHAR	1	74	74	On an institutional claim, the code that indicates the beneficiary stay under the prospective payment system which, although classified into a specific diagnosis related

group, has an unusually long length (day outlier) or exceptionally high cost (cost outlier).

DB2 ALIAS: DRG\_OUTLIER\_CD  
SAS ALIAS: OUTLR\_CD  
STANDARD ALIAS: CLM\_DRG\_OUTLIER\_STAY\_CD  
TITLE ALIAS: DRG\_OUTLIER\_STAY\_CODE

CODES:  
REFER TO: DRG\_OUTLIER\_STAY\_TB

SOURCE:  
CWF

20. Claim Excepted/Nonexcepted Medical Treatment Code

CHAR17575

Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI),

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is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

DB2 ALIAS: EXCPTD\_NEXCPTD\_CD  
SAS ALIAS: TRTMT\_CD  
STANDARD ALIAS: CLM\_EXCPTD\_NEXCPTD\_TRTMT\_CD  
TITLE ALIAS: EXCPTD\_NEXCPTD\_CD

CODES:  
0 = No Entry  
1 = Excepted  
2 = Nonexcepted

SOURCE:  
CWF

21. Claim Facility Type Code

CHAR17676

The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.

COMMON ALIAS: TOB1  
DB2 ALIAS: CLM\_FAC\_TYPE\_CD  
SAS ALIAS: FAC\_TYPE  
STANDARD ALIAS: CLM\_FAC\_TYPE\_CD  
TITLE ALIAS: TOB1

CODES:  
REFER TO: CLM\_FAC\_TYPE\_TB  
IN THE CODES APPENDIX

SOURCE:

CWF

22. Claim Frequency Code	CHAR	1	77	77	The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.
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COMMON ALIAS: TOB3  
DB2 ALIAS: CLM\_FREQ\_CD  
SAS ALIAS: FREQ\_CD  
STANDARD ALIAS: CLM\_FREQ\_CD  
SYSTEM ALIAS: LTFREQ  
TITLE ALIAS: FREQUENCY\_CD

CODES:  
REFER TO: CLM\_FREQ\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

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***	Claim Locator Number Group	GROUP	11	78	88	This number uniquely identifies the beneficiary in the NCH Nearline.  STANDARD ALIAS: CLM_LCTR_NUM_GRP
23.	Beneficiary Claim Account Number	CHAR	9	78	86	The number identifying the primary beneficiary under the SSA or RRB programs submitted.  This field is ENCRYPTED for the ENCRYPTED Standard View of the Inpatient/SNF files.  STANDARD ALIAS: BENE_CLM_ACNT_NUM  SOURCE: SSA, RRB  LIMITATIONS: RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.
24.	NCH Category Equatable Beneficiary Identification Code	CHAR	2	87	88	The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner. The equatable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the

record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.)

For the ENCRYPTED Standard View, this field contains the Beneficiary Identification Code. (See Field #7 of the FI Inpatient/SNF Claim Fixed Group - Encrypted Standard View.)

25. Claim MCO Paid Switch            CHAR            1        89    89    A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.

COBOL ALIAS: MCO\_PD\_IND  
DB2 ALIAS: CLM\_MCO\_PD\_SW  
SAS ALIAS: MCOPDSW  
STANDARD ALIAS: CLM\_MCO\_PD\_SW  
TITLE ALIAS: MCO\_PAID\_SW

CODES:  
1 = MCO has paid the provider for a claim  
Blank or 0 = MCO has not paid the provider for a claim

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COMMENT:  
Prior to Version H this field was named:  
CLM\_GHO\_PD\_SW.

SOURCE:  
CWF

26. Claim Medicare Non Payment    CHAR            1        90    90    The reason that no Medicare payment is made for services on an institutional claim.  
Reason Code

NOTE: Effective with Version I, this field was put on all institutional claim types.  
Prior to Version I, this field was present only on inpatient/SNF claims.

DB2 ALIAS: MDCR\_NPMT\_RSN\_CD  
SAS ALIAS: NOPAY\_CD  
STANDARD ALIAS: CLM\_MDCR\_NPMT\_RSN\_CD  
SYSTEM ALIAS: LTNPMT  
TITLE ALIAS: NON\_PAYMENT\_REASON

EDIT-RULES:  
OPTIONAL

CODES:  
REFER TO: CLM\_MDCR\_NPMT\_RSN\_TB  
IN THE CODES APPENDIX

SOURCE:

On an institutional claim, the number of days of care that are not chargeable to Medicare facility utilization.

```
DB2 ALIAS: NUTLZTN_DAY_CNT
SAS ALIAS: NUTILDAY
STANDARD ALIAS: CLM_NUTLZTN_DAY_CNT
TITLE ALIAS: NUTLZTN_DAYS
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SOURCE:  
CWF

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29.	Claim Other Physician UPIN Number	CHAR	6	103	108	On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional
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This field is ENCRYPTED for the ENCRYPTED Standard View of the Inpatient/SNF files.

COMMENT:  
Prior to Version H this field was named:  
CLM\_OTHR\_PHYSN\_IDENT\_NUM and contained  
10 positions (6-position UPIN and 4-position  
other physician surname).

SOURCE :  
CWF

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Medicare days for the current year (all PPS claims), as calculated by the FI and reimbursement staff. Items reimbursed as a pass through include capital-related costs; direct medical education costs; kidney acquisition costs for hospitals approved as RTCs; and bad debts (per Provider Reimbursement Manual, Part 1, Section 2405.2). \*\*Note: Pass throughs are not included in the Claim Payment Amount.

```
DB2 ALIAS: PASS_THRU_PER_DIEM
SAS ALIAS: PER_DIEM
STANDARD ALIAS: CLM_PASS_THRU_PER_DIEM_AMT
TITLE ALIAS: PER DIEM
```

COMMENT:  
Prior to Version H the field size was:  
S9(5)V99.

SOURCE :

CWF

31. Claim Payment Amount            CHAR        13    122   134   Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. \*\*NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). It does NOT include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

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				Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.
				Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate that the revenue center Medicare payment amount equals the claim level Medicare payment amount.
				Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).
				For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first

episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

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		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG END	
-----	----	-----	-----	-----

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT  
DB2 ALIAS: CLM\_PMT\_AMT  
SAS ALIAS: PMT\_AMT  
STANDARD ALIAS: CLM\_PMT\_AMT  
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:  
+9(9).99

COMMENT:  
Prior to Version H the size of this field was S9(7)V99. Also the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item

SOURCE :  
CWF

32. Claim PPS Capital Discharge	CHAR	7	135	141
Fraction Percent				

```
DB2 ALIAS: PPS_DSCHRG_PCT
SAS ALIAS: DSCHFRCT
STANDARD ALIAS: CLM_PPS_CPTL_DSCHRG_FRCTN_PCT
TITLE ALIAS: PPS_CAPITL_DSCHRG_FRACTION_PCT
```

SOURCE :  
CWF

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
33. Claim PPS Capital Disproportionate Share Amount	CHAR	13	142	154	Effective 3/2/92, the amount of disproportionate share (rate reflecting indigent population served) portion of the PPS payment for capital.

```
DB2 ALIAS: PPS_DSPRPRTNT_AMT
SAS ALIAS: DISP_SHR
STANDARD ALIAS: CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT
TITLE ALIAS: PPS DISP SHR
```

COMMENT:  
Prior to Version H the size of the field was:  
S9(7)V99.

SOURCE :  
CWF

34. Claim PPS Capital DRG Weight Number	CHAR	9	155	163	Effective 3/2/92, the number used to determine a transfer adjusted case mix index for capital PPS. The number is determined by multiplying the DRG weight times the discharge fraction.
---	------	---	-----	-----	---

### 3.4 DIGITS SIGNED

```
DB2 ALIAS: PPS_DRG_WT_NUM
SAS ALIAS: DRGWTAMT
STANDARD ALIAS: CLM_PPS_CPTL_DRG_WT_NUM
TITLE ALIAS: PPS_CAPITAL_DRG_WEIGHT_NUM
```

EDIT-RULES:  
+999.9(4)

SOURCE :  
CWF

35.	Claim PPS Capital Exception Amount	CHAR	13	164	176	Effective 3/2/92, the capital PPS amount of exception payments provided for hospitals with inordinately high levels of capital obligations. Exception payments expire at the end of the 10-year transition period.
-----	------------------------------------	------	----	-----	-----	--

## 9.2 DIGITS SIGNED

```
DB2 ALIAS: PPS_EXCPTN_AMT
SAS ALIAS: CPTL_EXP
STANDARD ALIAS: CLM_PPS_CPTL_EXCPTN_AMT
TITLE ALIAS: PPS_CPTL_EXCP
```

```
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```

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----	-----	-----	-----	-----	-----

EDIT-RULES:  
+9 (9) .99

COMMENT:  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE :  
CWF

36. Claim PPS Capital FSP Amount	CHAR	13	177	189	Effective 3/2/92, the amount of the federal specific portion of the PPS payment for capital.
----------------------------------	------	----	-----	-----	--

## 9.2 DIGITS SIGNED

```
DB2 ALIAS: PPS_CPTL_FSP_AMT
SAS ALIAS: CPTL_FSP
STANDARD ALIAS: CLM_PPS_CPTL_FSP_AMT
```

TITLE ALIAS: PPS\_CAPITAL\_FSP

EDIT-RULES:  
+9(9).99

COMMENT:  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE:  
CWF

37. Claim PPS Capital HSP Amount CHAR 13 190 202 Effective 3/2/92, the hospital specific portion of the PPS payment for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS\_CPTL\_HSP\_AMT  
SAS ALIAS: CPTL\_HSP  
STANDARD ALIAS: CLM\_PPS\_CPTL\_HSP\_AMT  
TITLE ALIAS: PPS\_CAPITAL\_HSP

EDIT-RULES:  
+9(9).99

COMMENT:  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE:  
CWF

38. Claim PPS Capital IME Amount CHAR 13 203 215 Effective 3/2/92, the amount of the indirect medical education (IME) (reimbursable amount for teaching hospitals only; an added amount passed by Congress to augment normal PPS payments for teaching hospitals to compensate them for higher patient

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		POSITIONS			
NAME	TYPE	LENGTH	BEG	END	CONTENTS
-----	----	-----	-----	-----	-----
					costs resulting from medical education programs for interns and residents) portion of the PPS payment for capital.
					9.2 DIGITS SIGNED
					DB2 ALIAS: PPS_CPTL_IME_AMT SAS ALIAS: IME_AMT STANDARD ALIAS: CLM_PPS_CPTL_IME_AMT TITLE ALIAS: PPS_CPTL_IME
					EDIT-RULES: +9(9).99
					COMMENT:

Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE:  
CWF

39. Claim PPS Capital Outlier Amount CHAR 13 216 228 Effective 3/2/92, the amount of the outlier portion of the PPS payment for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS\_OUTLIER\_AMT  
SAS ALIAS: CPTLOUTL  
STANDARD ALIAS: CLM\_PPS\_CPTL\_OUTLIER\_AMT  
TITLE ALIAS: PPS\_CPTL\_OUTLIER

EDIT-RULES:  
+9(9).99

COMMENT:  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE:  
CWF

40. Claim PPS Indicator Code CHAR 1 229 229 Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).

NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was populated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces.

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		POSITIONS			CONTENTS
NAME	TYPE	LENGTH	BEG	END	
-----	----	-----	-----	-----	-----
COBOL ALIAS: PPS_IND					
DB2 ALIAS: CLM_PPS_IND_CD					
SAS ALIAS: PPS_IND					
STANDARD ALIAS: CLM_PPS_IND_CD					
TITLE ALIAS: PPS_IND					
CODES:					
REFER TO: CLM_PPS_IND_TB					
IN THE CODES APPENDIX					
SOURCE:					
CWF					

41.	Claim PPS Old Capital Hold	CHAR	13	230	242	Effective 3/2/92, this amount is the hold harmless amount payable for old capital as computed by PRICER for providers with a payment code equal to 'A'. The hold harmless amount-old capital is 100 percent of the reasonable costs of old capital for sole community sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital.
	Harmless Amount					

## 9.2 DIGITS SIGNED

```
DB2 ALIAS: PPS_CPTL_HRMLS_AMT
SAS ALIAS: HLDHRMLS
STANDARD ALIAS: CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT
TITLE ALIAS: PPS CPTL HOLD HRMLS
```

EDIT-RULES:  
+9 (9) .99

COMMENT:  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE :  
CWF

42. Claim Principal Diagnosis Code	CHAR	5	243	247	The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.
------------------------------------	------	---	-----	-----	--

NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.

```
DB2 ALIAS: PRNCPAL_DGNS_CD
SAS ALIAS: PDGNS_CD
STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD
TITLE ALIAS: PRINCIPAL DIAGNOSIS
```

```
1      FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002
```

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

EDIT-RULES:  
ICD-9-CM

SOURCE :  
CWF

43. Claim Query Code	CHAR	1	248	248	Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).
----------------------	------	---	-----	-----	---

DB2 ALIAS: CLM QUERY CD

SAS ALIAS: QUERY\_CD  
STANDARD ALIAS: CLM\_QUERY\_CD  
TITLE ALIAS: QUERY\_CD

CODES:  
0 = Credit adjustment  
1 = Interim bill  
2 = Home Health Agency (HHA) benefits exhausted (obsolete 7/98)  
3 = Final bill  
4 = Discharge notice (obsolete 7/98)  
5 = Debit adjustment

SOURCE:  
CWF

44. Claim Service Classification Type Code      CHAR      1      249    249    The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary.

COMMON ALIAS: TOB2  
DB2 ALIAS: SRVC\_CLSFCTN\_CD  
SAS ALIAS: TYPESRVC  
STANDARD ALIAS: CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
TITLE ALIAS: TOB2

CODES:  
REFER TO: CLM\_SRVC\_CLSFCTN\_TYPE\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

45. Claim Source Inpatient Admission Code      CHAR      1      250    250    The code indicating the means by which the beneficiary was admitted to the inpatient health care facility or SNF if the type of admission is (1) emergency, (2) urgent, or (3) elective.

DB2 ALIAS: SRC\_IP\_ADMSN\_CD  
SAS ALIAS: SRC\_ADMS  
STANDARD ALIAS: CLM\_SRC\_IP\_ADMSN\_CD  
TITLE ALIAS: IP\_ADMISSION\_SOURCE

1      FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS			CONTENTS
NAME	TYPE	LENGTH	BEG	END	
-----	----	-----	-----	-----	-----

CODES:  
REFER TO: CLM\_SRC\_IP\_ADMSN\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

46. Claim Through Date      NUM      8      251    258    The last day on the billing statement covering services rendered to the beneficiary (a.k.a

'Statement Covers Thru Date').

For the ENCRYPTED Standard View of the Inpatient/SNF files, the claim through date is coded as the quarter of the calendar year when the claim through date occurred.

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM\_THRU\_DT  
SAS ALIAS: THRU\_DT  
STANDARD ALIAS: CLM\_THRU\_DT  
TITLE ALIAS: THRU\_DATE

EDIT-RULES FOR ENCRYPTED DATA:  
YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.  
1 = FIRST QUARTER OF THE CALENDAR YEAR  
2 = SECOND QUARTER OF THE CALENDAR YEAR  
3 = THIRD QUARTER OF THE CALENDAR YEAR  
4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:  
CWF

47. Claim Total Charge Amount CHAR 13 259 271 Effective with Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM\_TOT\_CHRG\_AMT  
SAS ALIAS: TOT\_CHRG  
STANDARD ALIAS: CLM\_TOT\_CHRG\_AMT  
TITLE ALIAS: CLAIM\_TOTAL\_CHARGES

EDIT-RULES:  
+9(9).99

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG END	
-----	----	-----	-----	-----
COMMENT: Prior to Version H the size of this field was S9(7)V99.				
SOURCE: CWF				

48. Claim Total PPS Capital Amount	CHAR	13	272	284	<div>The total amount that is payable for capital PPS for the claim. This is the sum of the capital hospital specific portion, federal specific portion, outlier portion, disproportionate share portion, indirect medical education portion, exception payments, and hold harmless payments.</div> <div>9.2 DIGITS SIGNED</div> <div>DB2 ALIAS: TOT_PPS_CPTL_AMT SAS ALIAS: PPS_CPTL STANDARD ALIAS: CLM_TOT_PPS_CPTL_AMT TITLE ALIAS: PPS_CAPITAL</div> <div>EDIT-RULES: +9(9).99</div> <div>COMMENT: Prior to Version H the size of this field was: S9(7)V99.</div> <div>SOURCE: CWF</div>
49. Claim Transaction Code	CHAR	1	285	285	<div>The code derived by CWF to indicate the type of claim submitted by an institutional provider.</div> <div>DB2 ALIAS: CLM_TRANS_CD SAS ALIAS: TRANS_CD STANDARD ALIAS: CLM_TRANS_CD SYSTEM ALIAS: LTCLTRAN TITLE ALIAS: TRANSACTION_CODE</div> <div>CODES: REFER TO: CLM_TRANS_TB IN THE CODES APPENDIX</div> <div>SOURCE: CWF</div>
50. Claim Utilization Day Count	CHAR	4	286	289	<div>On an institutional claim, the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days.</div>

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NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
-----	----	-----	-----	-----	-----	-----
						3 DIGITS SIGNED
						DB2 ALIAS: CLM_UTLZTN_DAY_CNT SAS ALIAS: UTIL_DAY STANDARD ALIAS: CLM_UTLZTN_DAY_CNT

TITLE ALIAS: UTILIZATION\_DAYS

EDIT-RULES:  
+999

SOURCE:  
CWF

51. CWF Beneficiary Medicare Status Code CHAR 2 290 291 The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM\_THRU\_DT).

COBOL ALIAS: MSC  
COMMON ALIAS: MSC  
DB2 ALIAS: BENE\_MDCR\_STUS\_CD  
SAS ALIAS: MS\_CD  
STANDARD ALIAS: CWF\_BENE\_MDCR\_STUS\_CD  
SYSTEM ALIAS: LTMSC  
TITLE ALIAS: MSC

DERIVATION:  
CWF derives MSC from the following:  
1. Date of Birth  
2. Claim Through Date  
3. Original/Current Reasons for entitlement  
4. ESRD Indicator  
5. Beneficiary Claim Number  
Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

CODES:  
10 = Aged without ESRD  
11 = Aged with ESRD  
20 = Disabled without ESRD  
21 = Disabled with ESRD  
31 = ESRD only

COMMENT:  
Prior to Version H this field was named:

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			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
-----					
BENE_MDCR_STUS_CD. The name has been changed to distinguish this CWF-derived field from the EDB-derived MSC (BENE_MDCR_STUS_CD).					

					SOURCE: CWF
52. FI Claim Action Code	CHAR	1	292	292	The type of action requested by the intermediary to be taken on an institutional claim.  DB2 ALIAS: FI_CLM_ACTN_CD SAS ALIAS: ACTIONCD STANDARD ALIAS: FI_CLM_ACTN_CD TITLE ALIAS: ACTION_CD  CODES: REFER TO: FI_CLM_ACTN_TB IN THE CODES APPENDIX  COMMENT: Prior to Version H this field was named: INTRMDRY_CLM_ACTN_CD.  SOURCE: CWF
53. FI Number	CHAR	5	293	297	The identification number assigned by HCFA to a fiscal intermediary authorized to process institutional claim records.  DB2 ALIAS: FI_NUM SAS ALIAS: FI_NUM STANDARD ALIAS: FI_NUM SYSTEM ALIAS: LTFI TITLE ALIAS: INTERMEDIARY  CODES: REFER TO: FI_NUM_TB IN THE CODES APPENDIX  COMMENT: Prior to Version H this field was named: FICARR_IDENT_NUM.  SOURCE: CWF
54. FI Requested Claim Cancel Reason Code	CHAR	1	298	298	The reason that an intermediary requested cancelling a previously submitted institutional claim.  DB2 ALIAS: RQST_CNCL_RSN_CD SAS ALIAS: CANCELCD STANDARD ALIAS: FI_RQST_CLM_CNCL_RSN_CD TITLE ALIAS: CANCEL_CD

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		POSITIONS		
NAME	TYPE	LENGTH	BEG	END
-----	----	-----	-----	-----

SOURCE :  
CWF

55. Inpatient/SNF Claim Diagnosis Code Count	NUM	2	299	300	The count of the number of diagnosis codes (both principal and other) reported on an inpatient/SNF claim. The purpose of this count is to indicate how many claim diagnosis trailers are present.
---	-----	---	-----	-----	---

2 DIGITS UNSIGNED

```
DB2 ALIAS: IP_CLM_DGNS_CD_CNT
SAS ALIAS: IPDGNCNT
STANDARD ALIAS: IP_CLM_DGNS_CD_CNT
```

```

EDIT-RULES:
RANGE: 0 TO 10

```

COMMENT:  
Prior to Version H this field was named:  
CLM\_OTHR\_DGNS\_CD\_CNT and the principal was  
not included in the count.

SOURCE :  
CWF

56. Inpatient/SNF Claim Procedure Code Count	NUM	2	301	302	The count of the number of procedure codes (both principal and other) reported on an inpatient/SNF claim. The purpose of this count is to indicate how many claim procedure trailers are present.
---	-----	---	-----	-----	---

2 DIGITS UNSIGNED

```
DB2 ALIAS: IP_PRCDR_CD_CNT
SAS ALIAS: IPPRCNT
STANDARD ALIAS: IP_CLM_PRCDR_CD_CNT
EDIT-RULES:
RANGE: 0 TO 6
```

COMMENT:  
Prior to Version H this field was named:  
CLM\_PRCDR\_CD\_CNT.

SOURCE :  
CWF

```
1      FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002
```

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	

57. Inpatient/SNF Claim Related Condition Code Count	NUM	2	303	304	<div>The count of the number of condition codes reported on an inpatient/SNF claim. The purpose of this count is to indicate how many condition code trailers are present.</div> <div>2 DIGITS UNSIGNED</div> <div>DB2 ALIAS: IP_RLT_COND_CD_CNT SAS ALIAS: IPCONCNT STANDARD ALIAS: IP_CLM_RLT_COND_CD_CNT</div> <div>EDIT-RULES: RANGE: 0 TO 30</div> <div>COMMENT: Prior to Version H this field was named: CLM_RLT_COND_CD_CNT.</div> <div>SOURCE: CWF</div>
58. Inpatient/SNF Claim Related Occurrence Code Count	NUM	2	305	306	<div>The count of the number of occurrence codes reported on an inpatient/SNF claim. The purpose of this count is to indicate how many occurrence code trailers are present.</div> <div>2 DIGITS UNSIGNED</div> <div>DB2 ALIAS: IP_OCRNC_CD_CNT SAS ALIAS: IPOCRCNT STANDARD ALIAS: IP_CLM_RLT_OCRNC_CD_CNT</div> <div>EDIT-RULES: RANGE: 0 TO 30</div> <div>COMMENT: Prior to Version H this field was named: CLM_RLT_OCRNC_CD_CNT.</div> <div>SOURCE: CWF</div>
59. Inpatient/SNF Claim Value Code Count	NUM	2	307	308	<div>The count of the number of value codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many value code trailers are present.</div> <div>2 DIGITS UNSIGNED</div> <div>DB2 ALIAS: IP_VAL_CD_CNT SAS ALIAS: IPVALCNT STANDARD ALIAS: IP_CLM_VAL_CD_CNT</div>

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		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG END	
-----	----	-----	-----	-----

EDIT-RULES:  
RANGE: 0 TO 36  
  
COMMENT:  
Prior to Version H this field was named:  
CLM\_VAL\_CD\_CNT.  
  
SOURCE:  
CWF

60. Inpatient/SNF Revenue Center Code Count      NUM            2    309   310   The count of the number of revenue codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many revenue center trailers are present.

2 DIGITS UNSIGNED  
  
DB2 ALIAS: IP\_REV\_CNTR\_CD\_CNT  
SAS ALIAS: IPREVCNT  
STANDARD ALIAS: IP\_REV\_CNTR\_CD\_I\_CNT

EDIT-RULES:  
RANGE: 0 TO 45  
  
COMMENT:  
Prior to Version H this field was named:  
CLM\_REV\_CNTR\_CD\_CNT.

NOTE: During the Version 'I' conversion the number of occurrences changed to 45 (per segment - 450 total for claim). For claims prior to Version 'I' the number of occurrences was 58, but in the conversion we made all claims back to service year 1991 contain only 45 revenue center lines. It is possible that claims prior to 1991 will have 2 segments if they contained more than 45 revenue lines.

SOURCE:  
CWF

61. NCH Beneficiary Blood Deductible Liability Amount      CHAR           13    311   323   The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible.

9.2 DIGITS SIGNED  
  
DB2 ALIAS: BLOOD\_DDCTBL\_AMT  
SAS ALIAS: BLDDDEDAM  
STANDARD ALIAS: NCH\_BENE\_BLOOD\_DDCTBL\_AMT  
TITLE ALIAS: BLOOD\_DEDUCTIBLE

		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG    END	
-----	----	-----	-----	-----

EDIT-RULES:  
+9(9).99

DERIVATION:  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
'06' move the corresponding value amount to  
NCH\_BENE\_BLOOD\_DDCTBL\_AMT.

COMMENT:  
Prior to Version H, this field was named:  
BENE\_BLOOD\_DDCTBL\_LBLTY\_AMT and the field  
size was S9(5)V99. Also, for OP claims, this  
field was stored in a blood trailer. Version  
H eliminated the OP blood trailer.

SOURCE:  
NCH QA PROCESS

62. NCH Beneficiary Discharge Date NUM 8 324 331 Effective with Version H, on an inpatient and  
HHA claim, the date the beneficiary was discharged  
from the facility or died (used for internal CWFMQA  
editing purposes.)

For the ENCRYPTED Standard View of the  
Inpatient/SNF files, the beneficiary's  
discharge date is coded as the quarter  
of the calendar year when the discharge  
occurred.

NOTE: During the Version H conversion this field  
was populated with data throughout history (back to  
service year 1991.)

8 DIGITS UNSIGNED

DB2 ALIAS: NCH\_BENE\_DSCHRG\_DT  
SAS ALIAS: DSCHRGDT  
STANDARD ALIAS: NCH\_BENE\_DSCHRG\_DT  
TITLE ALIAS: DISCHARGE\_DT

EDIT-RULES FOR ENCRYPTED DATA:  
YYYYQ000 WHERE Q IS ONE OF THE  
FOLLOWING VALUES.  
1 = FIRST QUARTER OF THE CALENDAR YEAR  
2 = SECOND QUARTER OF THE CALENDAR YEAR  
3 = THIRD QUARTER OF THE CALENDAR YEAR  
4 = FOURTH QUARTER OF THE CALENDAR YEAR

POSITIONS					CONTENTS
NAME	TYPE	LENGTH	BEG	END	

					DERIVATION: DERIVED FROM: NCH_PTNT_STUS_IND_CD CLM_THRU_DT  DERIVATION RULES: Based on the presence of patient discharge status code not equal to 30 (still patient), move the claim thru date to the NCH_BENE_DSCHRG_DT.  SOURCE: NCH QA Process
63. NCH Inpatient Total Deduction Amount	CHAR	13	332	344	Effective with Version H, the total Part A deductions reported on the Inpatient claim (used for internal CWFMQA editing purposes).  NOTE: During the Version H conversion this field was populated with data throughout history (back to 1991), but the derivation rule applied was in- complete for claims processed prior to 10/93. Disregard any data present in this field on claims with NCH weekly process date earlier than 10/93.  9.2 DIGITS SIGNED  DB2 ALIAS: IP_TOT_DDCTN_AMT SAS ALIAS: TDEDAMT STANDARD ALIAS: NCH_IP_TOT_DDCTN_AMT TITLE ALIAS: IP_TOT_DEDUCTIONS  EDIT-RULES: +9(9).99  DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT  DERIVATION RULES (Effective 10/93): Accumulate the value amounts associated with value codes equal to 06, 08 thru 11 and A1, B1 or C1 and move to IP_TOT_DDCTN_AMT. NOTE: Value codes 08-11 did not exist in the NCH prior to 2/93; values codes A1, B1, C1 did not exist prior to 10/93.  SOURCE: NCH QA Process
64. NCH Beneficiary Part A Coinsurance Liability Amount	CHAR	13	345	357	The amount of money for which the intermediary has determined that the beneficiary is liable for Part A coinsurance on the institutional claim.

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----					
					9.2 DIGITS SIGNED
					DB2 ALIAS: PTA_COINSRNC_AMT
					SAS ALIAS: COIN_AMT
					STANDARD ALIAS: NCH_BENE_PTA_COINSRNC_AMT
					TITLE ALIAS: BENE_PTA_COINSURANCE
					EDIT-RULES:
					+9(9).99
					DERIVATION:
					DERIVED FROM:
					CLM_VAL_CD
					CLM_VAL_AMT
					DERIVATION RULES:
					Based on the presence of value code equal to
					8, 9, 10 or 11 move the corresponding value
					amount to the NCH_BENE_IP_PTA_COINSRC_AMT.
					COMMENT:
					Prior to Version H this field was named:
					BENE_PTA_COINSRNC_LBLTY_AMT and the field size
					was S9(5)V99.
					SOURCE:
					NCH
NCH Blood Deductible Pints Quantity	CHAR	4	358	361	The quantity of blood pints applied (blood deductible).
					3 DIGITS SIGNED
					DB2 ALIAS: BLOOD_DDCTBL_QTY
					SAS ALIAS: BLDDDEDPT
					STANDARD ALIAS: NCH_BLOOD_DDCTBL_PT_QTY
					TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE
					EDIT-RULES:
					+999
					DERIVATION:
					DERIVED FROM:
					CLM_VAL_CD
					CLM_VAL_AMT
					DERIVATION RULES:
					Based on the presence of value code equal to
					38 move the related value amount to the
					NCH_BLOOD_DDCTBL_PT_QTY.

NAME	TYPE	LENGTH	BEG	END	CONTENTS
					COMMENT: Prior to Version H this field was named: CLM_BLOOD_DDCTBL_PT_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.
					SOURCE: NCH QA Process
66. NCH Blood Non-Covered Charge Amount	CHAR	13	362	374	Effective with Version H, the total noncovered charges for blood usage (for internal CWFMQA editing purposes).  NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).  9.2 DIGITS SIGNED  DB2 ALIAS: BLOOD_NCVR_AMT DB2 ALIAS: BLOOD_NCVR_AMT SAS ALIAS: BLDNCHRG STANDARD ALIAS: NCH_BLOOD_NCOV_CHRG_AMT TITLE ALIAS: BLOOD_NCV_CHARGES  EDIT-RULES: +9(9).99  DERIVATION: DERIVED FROM: REV_CNTR_CD REV_CNTR_NCOV_CHRG_AMT  DERIVATION RULES: Based on the presence of revenue center codes equal to 0380 thru 0389 move the related noncovered charges to NCH_BLOOD_NCOV_CHRG_AMT.  SOURCE: NCH QA Process
67. NCH Blood Pints Furnished Quantity	CHAR	4	375	378	Number of whole pints of blood furnished to the beneficiary.  3 DIGITS SIGNED  DB2 ALIAS: NCH_BLOOD_PT_FRNSH SAS ALIAS: BLDFRNSH STANDARD ALIAS: NCH_BLOOD_PT_FRNSH_QTY TITLE ALIAS: BLOOD_PINTS_FURNISHED

NAME	TYPE	LENGTH	BEG	END	CONTENTS
					EDIT-RULES: +999
					DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT
					DERIVATION RULES: Based on the presence of value code equal to 37 move the related value amount to the NCH_BLOOD_PT_FRNSH_QTY.
					COMMENT: Prior to Version H this field was named: CLM_BLOOD_PT_FRNSH_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.
					SOURCE: NCH QA Process
68. NCH Blood Pints Not Replaced Quantity	CHAR	4	379	382	Number of whole pints of blood not replaced.  3 DIGITS SIGNED  DB2 ALIAS: BLOOD_PT_NRPLC_QTY SAS ALIAS: BLDNRPLC STANDARD ALIAS: NCH_BLOOD_PT_NRPLC_QTY TITLE ALIAS: BLOOD_PINTS_NOT_REPLACED  EDIT-RULES: +999  DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT  DERIVATION RULES: Subtract value code 39 amount from value code 37 amount and move the result to NCH_BLOOD_PT_NRPLC_QTY.  COMMENT: Prior to Version H this field was named: CLM_BLOOD_PT_NRPLC_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.  SOURCE: NCH QA Process

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
69. NCH Blood Pints Replaced Quantity	CHAR	4	383	386	Number of whole pints of blood replaced.  3 DIGITS SIGNED  DB2 ALIAS: BLOOD_PT_RPLC_QTY SAS ALIAS: BLD_RPLC STANDARD ALIAS: NCH_BLOOD_PT_RPLC_QTY TITLE ALIAS: BLOOD_PINTS_REPLACED  EDIT-RULES: +999  DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT  DERIVATION RULES: Based on the presence of value code equal to 39 move the related value amount to the NCH_BLOOD_PT_RPLC_QTY.  COMMENT: Prior to Version H this field was named: CLM_BLOOD_PT_RPLC_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.  SOURCE: NCH QA Process
70. NCH Blood Total Charge Amount	CHAR	13	387	399	Effective with Version H, the total charge for blood usage (for internal CWFMQA editing purposes).  NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).  9.2 DIGITS SIGNED  DB2 ALIAS: BLOOD_TOT_CHRG_AMT SAS ALIAS: BLDTCHRG STANDARD ALIAS: NCH_BLOOD_TOT_CHRG_AMT TITLE ALIAS: BLOOD_CHARGES  EDIT-RULES: +9(9).99  DERIVATION: DERIVED FROM:

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					<p>DERIVATION RULES: Based on the presence of revenue center codes 0380 thru 0389 move the related total charge amount to the NCH_BLOOD_TOT_CHRG_AMT.</p> <p>SOURCE: NCH QA Process</p>
71. NCH DRG Outlier Approved Payment Amount	CHAR	13	400	412	<p>On an institutional claim, the additional payment amount approved by the Peer Review Organization due to an outlier situation for a beneficiary's stay under the prospective payment system, which has been classified into a specific diagnosis related group.</p> <p>9.2 DIGITS SIGNED</p> <p>DB2 ALIAS: DRG_OUTLIER_AMT SAS ALIAS: OUTLRPMT STANDARD ALIAS: NCH_DRG_OUTLIER_APRV_PMT_AMT TITLE ALIAS: DRG_OUTLIER_PMT</p> <p>EDIT-RULES: +9(9).99</p> <p>DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT</p> <p>DERIVATION RULES: Based on the presence of value code equal to 17 move the related amount to NCH_DRG_OUTLIER_APRV_PMT_AMT.</p> <p>COMMENT: Prior to Version H this field was named: CLM_DRG_OUTLIER_APRV_PMT_AMT and field size was S9(7)V99.</p> <p>SOURCE: NCH QA Process</p>
72. NCH Near Line Record Identification Code	CHAR	1	413	413	<p>A code defining the type of claim record being processed.</p> <p>COMMON ALIAS: RIC DB2 ALIAS: NEAR_LINE_RIC_CD SAS ALIAS: RIC_CD STANDARD ALIAS: NCH NEAR LINE RIC CD</p>

		TITLE ALIAS: RIC			
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		POSITIONS			
		NAME	TYPE	LENGTH	BEG END CONTENTS
		-----	----	-----	-----
		CODES:			
		REFER TO: NCH_NEAR_LINE_RIC_TB			
		IN THE CODES APPENDIX			
		COMMENT:			
		Prior to Version H this field was named:			
		RIC_CD.			
		SOURCE:			
		NCH			
73.	NCH Near-Line Record Version Code	CHAR	1	414 414	The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored:
		DB2 ALIAS: NCH_REC_VRSN_CD			
		SAS ALIAS: REC_LVL			
		STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD			
		TITLE ALIAS: NCH_VERSION			
		CODES:			
		A = Record format as of January 1991			
		B = Record format as of April 1991			
		C = Record format as of May 1991			
		D = Record format as of January 1992			
		E = Record format as of March 1992			
		F = Record format as of May 1992			
		G = Record format as of October 1993			
		H = Record format as of September 1998			
		I = Record format as of July 2000			
		COMMENT:			
		Prior to Version H this field was named:			
		CLM_NEAR_LINE_REC_VRSN_CD			
		SOURCE:			
		NCH			
		COMMENT:			
		Prior to Version H this field was named:			
		CLM_NEAR_LINE_REC_VRSN_CD			
		SOURCE:			
		NCH			

		POSITIONS			
		NAME	TYPE	LENGTH	BEG END CONTENTS

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74.	NCH Patient Status Indicator Code	CHAR	1	415	415	Effective with Version H, the code on an inpatient/SNF and Hospice claim, indicating whether the beneficiary was discharged, died or still a patient (used for internal CWFMQA editing purposes.)			
						NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).			
						DB2 ALIAS: NCH_PTNT_STUS_IND SAS ALIAS: PTNTSTUS STANDARD ALIAS: NCH_PTNT_STUS_IND_CD TITLE ALIAS: NCH_PATIENT_STUS			
						DERIVATION: DERIVED FROM: NCH_PTNT_DSCHRG_STUS_CD			
						DERIVATION RULES:  SET NCH_PTNT_STUS_IND_CD TO 'A' WHERE THE PTNT_DSCHRG_STUS_CD NOT EQUAL TO '20' - '30' OR '40' - '42'.  SET NCH_PTNT_STUS_IND_CD TO 'B' WHERE THE PTNT_DSCHRG_STUS_CD EQUAL TO '20' - '29' OR '40' - '42'.  SET NCH_PTNT_STUS_IND_CD TO 'C' WHERE THE PTNT_DSCHRG_STUS_CD EQUAL TO '30'			
						CODES: A = Discharged B = Died C = Still patient			
						SOURCE: NCH QA Process			
75.	NCH Payment and Edit Record Identification Code	CHAR	1	416	416	The code used for payment and editing purposes that indicates the type of institutional claim record.			
						DB2 ALIAS: PMT_EDIT_RIC_CD SAS ALIAS: PE_RIC STANDARD ALIAS: NCH_PMT_EDIT_RIC_CD TITLE ALIAS: NCH_PAYMENT_EDIT_REC			
						CODES: C = Inpatient hospital, SNF D = Outpatient E = Religious Nonmedical Health Care Institutions (eff. 8/00			

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					Christian Science, prior to 7/00 F = Home Health Agency (HHA) G = Discharge notice (obsoleted 7/98) I = Hospice  COMMENT: Prior to Version H this field was named: PMT_EDIT_RIC_CD.  SOURCE: NCH QA Process
NCH Primary Payer Claim Paid Amount	CHAR	13	417	429	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim.  9.2 DIGITS SIGNED  DB2 ALIAS: PRMRY_PYR_PD_AMT SAS ALIAS: PRPAYAMT STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT TITLE ALIAS: PRIMARY_PAYER_AMOUNT  EDIT-RULES: +9(9).99  COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_CLM_PMT_AMT and the field size was S9(7)V99.  SOURCE: NCH
NCH Primary Payer Code	CHAR	1	430	430	The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills.  DB2 ALIAS: NCH_PRMRY_PYR_CD SAS ALIAS: PRPAY_CD STANDARD ALIAS: NCH_PRMRY_PYR_CD TITLE ALIAS: PRIMARY_PAYER_CD  DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT  DERIVATION RULES

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE CLM_VAL_CD = '12'
					SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE CLM_VAL_CD = '13'
					SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes
					SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE CLM_VAL_CD = '14'
					SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE CLM_VAL_CD = '15'
					SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE CLM_VAL_CD = '16' (CLM_VAL_AMT not equal to zeroes)
					SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE CLM_VAL_CD = '43'
					SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE CLM_VAL_CD = '41'
					SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE CLM_VAL_CD = '42'
					SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97 set code to 'J') WHERE THE CLM_VAL_CD = '47'
					CODES: REFER TO: BENE_PRMRY_PYR_TB IN THE CODES APPENDIX
					COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_CD.
					SOURCE: NCH
78. NCH Professional Component Charge Amount	CHAR	13	431	443	Effective with Version H, for inpatient and out- patient claims, the amount of physician and other professional charges covered under Medicare Part B (used for internal CWFMQA editing purposes and other internal processes (e.g. if computing interim payment these charges are deducted)).  NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

9.2 DIGITS SIGNED

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		POSITIONS				
NAME	TYPE	LENGTH	BEG	END	CONTENTS	
					-----	
					DB2 ALIAS: PROFNL_CMPNT_AMT	
					SAS ALIAS: PCCHGAMT	
					STANDARD ALIAS: NCH_PROFNL_CMPNT_CHRG_AMT	
					TITLE ALIAS: PROFNL_CMPNT_CHARGES	
					EDIT-RULES:	
					+9(9).99	
					DERIVATION:	
					1. IF INPATIENT - DERIVED FROM:	
					CLM_VAL_CD	
					Clm_VAL_AMT	
					DERIVATION RULES:	
					Based on the presence of value code 04 or 05	
					move the related value amount to the	
					NCH_PROFNL_CMPNT_CHRG_AMT.	
					2. IF OUTPATIENT - DERIVED FROM:	
					REV_CNTR_CD	
					REV_CNTR_TOT_CHRG_AMT	
					DERIVATION RULES (Effective 10/98):	
					Based on the presence of revenue center codes	
					096X, 097X & 098X move the related total charge	
					amount to NCH_PROFNL_CMPNT_CHRG_AMT.	
					NOTE1: During the Version H conversion, this	
					field was populated with data throughout history	
					BUT the derivation rule applied to the outpatient	
					claim was incomplete (i.e., revenue codes 0972,	
					0973, 0974 and 0979 were omitted from the calcu-	
					lation).	
					SOURCE:	
					NCH QA Process	
79. NCH Provider State Code	CHAR	2	444	445	Effective with Version H, the two position SSA state code	
					where provider facility is located.	
					NOTE: During the Version H conversion this field was	
					populated with data throughout history (back to service year	
					1991).	
					DB2 ALIAS: NCH_PRVDR_STATE_CD	
					SAS ALIAS: PRSTATE	
					STANDARD ALIAS: NCH_PRVDR_STATE_CD	
					TITLE ALIAS: PROVIDER_STATE_CD	

DERIVATION:  
DERIVED FROM:  
NCH PRVDR\_NUM

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NAME		TYPE	LENGTH	POSITIONS		CONTENTS
-----		----	-----	BEG	END	-----
DERIVATION RULES:						
SET NCH_PRVDR_STATE_CD TO PRVDR_NUM POS1-2. FOR PRVDR_NUM POS1-2 EQUAL '55' SET NCH_PRVDR_STATE_CD TO '05'. FOR PRVDR_NUM POS1-2 EQUAL '67' SET NCH_PRVDR_STATE_CD TO '45'. FOR PRVDR_NUM POS1-2 EQUAL '68' SET NCH_PRVDR_STATE_CD TO '10'.						
CODES:						
REFER TO: GEO_SSA_STATE_TB IN THE CODES APPENDIX						
SOURCE:						
NCH						
80.	NCH Qualify Stay Through Date	NUM	8	446	453	Effective with Version H, the ending date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes.) For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than 'A'.  For the ENCRYPTED Standard View of the Inpatient/ SNF files, the beneficiary's qualifying stay through date is coded as the quarter of calendar year when the stay through date occurred.  NOTE: During the Version H, conversion this field was populated with data throughout history (back to service year 1991).  8 DIGITS UNSIGNED  DB2 ALIAS: QLFY_STAY_THRU_DT SAS ALIAS: QLFYTHRU STANDARD ALIAS: NCH_QLFY_STAY_THRU_DT TITLE ALIAS: QLFYG_STAY_THRU_DT  EDIT-RULES FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE

FOLLOWING VALUES.  
1 = FIRST QUARTER OF THE CALENDAR YEAR  
2 = SECOND QUARTER OF THE CALENDAR YEAR  
3 = THIRD QUARTER OF THE CALENDAR YEAR  
4 = FOURTH QUARTER OF THE CALENDAR YEAR

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NAME		TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
						DERIVATION: DERIVED FROM: CLM_OCRNC_SPAN_CD CLM_OCRNC_SPAN_THRU_DT  DERIVATION RULES: Based on the presence of occurrence code 70 move the related occurrence thru date to NCH_QLFY_STAY_THRU_DT.  SOURCE: NCH QA Process
81. Patient Discharge Status Code		CHAR	2	454	455	The code used to identify the status of the patient as of the CLM_THRU_DT.  COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS DB2 ALIAS: PTNT_DSCHRG_STUS SAS ALIAS: STUS_CD STANDARD ALIAS: PTNT_DSCHRG_STUS_CD SYSTEM ALIAS: LTCLMST TITLE ALIAS: PTNT_DSCHRG_STUS_CD  CODES: REFER TO: PTNT_DSCHRG_STUS_TB IN THE CODES APPENDIX  COMMENT: Prior to Version H this field was named: CLM_STUS_CD.  SOURCE: CWF
82. Provider Number		CHAR	6	456	461	The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.  DB2 ALIAS: PRVDR_NUM SAS ALIAS: PROVIDER STANDARD ALIAS: PRVDR_NUM TITLE ALIAS: PROVIDER_NUMBER  CODES: REFER TO: PRVDR_NUM_TB IN THE CODES APPENDIX

		SOURCE: OSCAR			
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83.	HEADER-GRP.	GROUP	50		
1.	System-User	CHAR	30 462	491	A user-defined field that holds the description of the request. For example, "Cross-referenced HICs".
2.	Filler	CHAR	11 492	502	Filler
3.	Desy-Sort-Key	CHAR	9 503	511	This field contains the key to tie claims together for one beneficiary regardless of HICAN.
*****					
C L A I M       D I A G N O S I S       G R O U P       R E C O R D					
*****					
		POSITIONS			
	NAME	TYPE	LENGTH	BEG	END
-----		----	-----	-----	-----
****	FI Inpatient/Skilled Nursing Facility Claim Diagnosis Group Record - Encrypted Standard View	GROUP	26	Claim Diagnosis Group Record for the Encrypted Standard View of the Inpatient/Skilled Nursing Facility version I NCH Nearline File.  The number of claim diagnosis trailers is determined by the claim diagnosis code count. The principal diagnosis is the first occurrence. The 'E' code (ICD-9-CM code for the external cause of an injury, poisoning, or adverse affect) is stored as the last occurrence. The principal diagnosis and the 'E' code are also stored (redundantly) in the fixed record.  NOTE: Prior to Version H this group was named: CLM_OTHR_DGNS_GRP and did not contain the CLM_PRNCPAL_DGNS_CD.  OCCURS: UP TO 10 TIMES DEPENDING ON IP_CLM_DGNS_CD_CNT  STANDARD ALIAS: UTLIPSNI_CLM_DGNS_GRP	
1.	Record Length Count	NUM	5	1	5 The length of the ClaimDiagnosis Group Record.

STANDARD ALIAS: TRAIL\_BYTE\_COUNT

STANDARD ALIAS: TRAIL\_CLAIM\_NO

STANDARD ALIAS: TRAIL\_REC\_TYPE

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group 10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim.  STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH.  NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991).  NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.  STANDARD ALIAS: TRAIL NCH CLM TYPE CD

DERIVATION:  
FFS CLAIM TYPE CODES DERIVED FROM:  
NCH CLM\_NEAR\_LINE\_RIC\_CD  
NCH PMT\_EDIT\_RIC\_CD  
NCH CLM\_TRANS\_CD  
NCH PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(Pre-HDC processing -- AVAILABLE IN NCH)  
CLM\_MCO\_PD\_SW  
CLM\_RLT\_COND\_CD  
MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(HDC processing -- AVAILABLE IN NMUD)  
FI\_NUM

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NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
<p>INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.</p> <p>PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM</p> <p>OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM</p> <p>OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD</p> <p>DERIVATION RULES:</p> <p>SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'</p>						

2. PMT\_EDIT\_RIC\_CD EQUAL 'F'  
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'  
3. CLM\_TRANS\_CD EQUAL '6'

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
<hr/>					
					SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'W' 2. PMT_EDIT_RIC_CD EQUAL 'D' 3. CLM_TRANS_CD EQUAL '6' 4. FI_NUM = 80881
					SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED' ENCOUNTER CLAIMS -- AVAILABLE IN NMUD) 1. FI_NUM = 80881 2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_ CLSFACTN_TYPE_CD = '2', '3' OR '4' & CLM_FREQ_CD = 'Z', 'Y' OR 'X'
					SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'I' 3. CLM_TRANS_CD EQUAL 'H'
					SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V' 2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E' 3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
					SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER

CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -  
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_MCO\_PD\_SW = '1'  
2. CLM\_RLT\_COND\_CD = '04'  
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET\_CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE  
FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'  
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (INPATIENT 'ABBREVIATED'  
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE  
THE FOLLOWING CONDITIONS ARE MET:  
1. FI\_NUM = 80881 AND  
2. CLM\_FAC\_TYPE\_CD = '1'; CLM\_SRVC\_CLSFCTN\_  
TYPE\_CD = '1'; CLM\_FREQ\_CD = 'Z'

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS			
NAME	TYPE	LENGTH	BEG	END	CONTENTS
-----					
					SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD not on DMEPOS table
					SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).
					SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CARR_NUM = 80882 AND 2. CLM_DEMO_ID_NUM = 38
					SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD not on DMEPOS table
					SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'

2. HCPCS\_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES:  
REFER TO: NCH\_CLM\_TYPE\_TB  
IN THE CODES APPENDIX

SOURCE:  
NCH

6. Claim Diagnosis Code CHAR 5 22 26 The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:  
Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM\_PRNCPAL\_DGNS\_CD was added as the first occurrence.

DB2 ALIAS: CLM\_DGNS\_CD  
SAS ALIAS: DGNS\_CD  
STANDARD ALIAS: CLM\_DGNS\_CD  
TITLE ALIAS: DIAGNOSIS

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG END	
-----	----	-----	-----	-----

EDIT-RULES:  
ICD-9-CM  
  
COMMENT:  
Prior to Version H this field was named:  
CLM\_OTHR\_DGNS\_CD.

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

\*\*\*\*\*  
  
C L A I M P R O C E D U R E G R O U P R E C O R D  
  
\*\*\*\*\*

		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG END	
-----	----	-----	-----	-----

\*\*\*\* FI Inpatient/Skilled Nursing Facility Claim Procedure Group Record - Claim Procedure Group Record for the Encrypted Standard View of the Inpatient/Skilled Nursing Facility

The number of claim procedure trailers is determined by the claim procedure code count. Prior to 10/93 up to 10 occurrences could be reported on an institutional claim. Beginning 10/93, up to six occurrences (one principal; five others) may be reported.

OCCURS: UP TO 6 TIMES  
DEPENDING ON IP\_CLM\_PRCDR\_CD\_CNT

STANDARD ALIAS: UTLIPSNI\_CLM\_PRCDR\_GRP

1. Record Length Count	NUM	5	1	5	The length of the Claim Procedure Group Record.  5 DIGITS UNSIGNED  STANDARD ALIAS: TRAIL_BYTE_COUNT
2. Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim.  STANDARD ALIAS: TRAIL_CLAIM_NO
3. Record Type	NUM	2	15	16	Type of Record.  STANDARD ALIAS: TRAIL_REC_TYPE  CODES: 00 = Fixed/Main Group 01 = Carrier Line Group 02 = Claim Demonstration ID Group 03 = Claim Diagnosis Group 04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group
1	FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002				
		POSITIONS			
NAME	TYPE	LENGTH	BEG	END	CONTENTS
-----	----	-----	-----	-----	-----
				10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group	
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim.  STANDARD ALIAS: TRAIL_CLAIM_SEQ

5. NCH Claim Type CodeCHAR22021The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

STANDARD ALIAS: TRAIL\_NCH\_CLM\_TYPE\_CD

DERIVATION:  
FFS CLAIM TYPE CODES DERIVED FROM:  
NCH CLM\_NEAR\_LINE\_RIC\_CD  
NCH PMT\_EDIT\_RIC\_CD  
NCH CLM\_TRANS\_CD  
NCH PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(Pre-HDC processing -- AVAILABLE IN NCH)  
CLM\_MCO\_PD\_SW  
CLM\_RLT\_COND\_CD  
MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(HDC processing -- AVAILABLE IN NMUD)  
FI\_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)  
FI\_NUM  
CLM\_FAC\_TYPE\_CD  
CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
CLM\_FREQ\_CD

1FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS			CONTENTS	
NAME	TYPE	LENGTH	BEG	END		
-----						
NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.						
PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM						

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(AVAILABLE IN NMUD)  
FI\_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE  
DERIVED FROM: (AVAILABLE IN NMUD)  
FI\_NUM  
CLM\_FAC\_TYPE\_CD  
CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
CLM\_FREQ\_CD

DERIVATION RULES:

SET CLM\_TYPE\_CD TO 10 (HHA CLAIM) WHERE THE  
FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V','W' OR 'U'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'F'  
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'  
3. CLM\_TRANS\_CD EQUAL '6'  
SET CLM\_TYPE\_CD TO 41 (OUTPATIENT 'FULL'  
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE  
THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'

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		POSITIONS			
NAME	TYPE	LENGTH	BEG	END	CONTENTS
-----					
					2. PMT_EDIT_RIC_CD EQUAL 'D'
					3. CLM_TRANS_CD EQUAL '6'
					4. FI_NUM = 80881
					SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
					ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
					1. FI_NUM = 80881

2. CLM\_FAC\_TYPE\_CD = '1' OR '8'; CLM\_SRVC\_
CLSFACTN\_TYPE\_CD = '2', '3' OR '4' &
CLM\_FREQ\_CD = 'Z', 'Y' OR 'X'

SET CLM\_TYPE\_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'I'
3. CLM\_TRANS\_CD EQUAL 'H'

SET CLM\_TYPE\_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM\_MCO\_PD\_SW = '1'
2. CLM\_RLT\_COND\_CD = '04'
3. MCO\_CNTRCT\_NUM
MCO\_OPTN\_CD = 'C'
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. FI\_NUM = 80881 AND
2. CLM\_FAC\_TYPE\_CD = '1'; CLM\_SRVC\_CLSFCTN\_
TYPE\_CD = '1'; CLM\_FREQ\_CD = 'Z'

SET CLM\_TYPE\_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'
2. HCPCS\_CD not on DMEPOS table

		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG END	
-----				
SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)				
WHERE THE FOLLOWING CONDITIONS ARE MET:				
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'				
2. HCPCS_CD on DMEPOS table (NOTE: if one or				
more line item(s) match the HCPCS on the				

DMEPOS table).

SET CLM\_TYPE\_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--  
EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING  
CONDITIONS ARE MET:  
1. CARR\_NUM = 80882 AND  
2. CLM\_DEMO\_ID\_NUM = 38

SET CLM\_TYPE\_CD TO 81 (RIC M non-DMEPOS DMERC  
CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'  
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 82 (RIC M DMEPOS DMERC CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'  
2. HCPCS\_CD on DMEPOS table (NOTE: if one or  
more line item(s) match the HCPCS on the  
DMEPOS table).

CODES:  
REFER TO: NCH\_CLM\_TYPE\_TB  
IN THE CODES APPENDIX

SOURCE:  
NCH

6. Claim Procedure Code	CHAR	4	22	25	The ICD-9-CM code that indicates the principal or other procedure performed during the period covered by the institutional claim.
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DB2 ALIAS: CLM\_PRCDR\_CD  
SAS ALIAS: PRCDR\_CD  
STANDARD ALIAS: CLM\_PRCDR\_CD  
TITLE ALIAS: PROCEDURE\_CODE

EDIT-RULES:  
ICD-9-CM

SOURCE:  
CWF

7. Claim Procedure Performed Date	NUM	8	26	33	On an institutional claim, the date on which the principal or other procedure was performed.
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For the ENCRYPTED Standard View of the Inpatient/SNF files, the claim procedure

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		POSITIONS			CONTENTS
NAME	TYPE	LENGTH	BEG	END	
-----	----	-----	-----	-----	-----
					performed date is coded as the quarter of the calendar year when the procedure was performed.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM\_PRCDR\_PRFRM\_DT  
SAS ALIAS: PRCDR\_DT  
STANDARD ALIAS: CLM\_PRCDR\_PRFRM\_DT  
TITLE ALIAS: PROCEDURE\_DATE

EDIT-RULES FOR ENCRYPTED DATA:  
YYYYQ000 WHERE Q IS ONE OF THE  
FOLLOWING VALUES.  
1 = FIRST QUARTER OF THE CALENDAR YEAR  
2 = SECOND QUARTER OF THE CALENDAR YEAR  
3 = THIRD QUARTER OF THE CALENDAR YEAR  
4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:  
CWF

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C L A I M R E L A T E D C O N D I T I O N G R O U P R E C O R D

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NAME		TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
<hr/>						
****	FI Inpatient/Skilled Nursing Facility Claim Related Condition Group Record - Encrypted Standard View	GROUP	23			Claim Related Condition Group Record for the Encrypted Standard View of the Inpatient/Skilled Nursing Facility version I NCH Nearline File.  The number of claim related condition trailers is determined by the claim related condition code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.  OCCURS: UP TO 30 TIMES DEPENDING ON IP_CLM_RLT_COND_CD_CNT  STANDARD ALIAS: UTLIPSNI_CLM_RLT_COND_GRP
1.	Record Length Count	NUM	5	1	5	The length of the Claim Related Condition Group Record.  5 DIGITS UNSIGNED  STANDARD ALIAS: TRAIL_BYTE_COUNT

2. Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim.
					STANDARD ALIAS: TRAIL_CLAIM_NO
3. Record Type	NUM	2	15	16	Type of Record.
					STANDARD ALIAS: TRAIL_REC_TYPE
					CODES:
					00 = Fixed/Main Group
					01 = Carrier Line Group
					02 = Claim Demonstration ID Group
					03 = Claim Diagnosis Group
					04 = Claim Health PlanID Group
					05 = Claim Occurrence Span Group
					06 = Claim Procedure Group
					07 = Claim Related Condition Group
					08 = Claim Related Occurrence Group
1	FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002				
	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
	-----	----	-----	-----	-----
					09 = Claim Value Group
					10 = MCO Period Group
					11 = NCH Edit Group
					12 = NCH Patch Group
					13 = DMERC Line Group
					14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim.
					STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH.
					NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991).
					NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.
					STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD
					DERIVATION:
					FFS CLAIM TYPE CODES DERIVED FROM:
					NCH CLM_NEAR_LINE_RIC_CD

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FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.
					PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM
					OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM
					OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD
					DERIVATION RULES:  SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U' 2. PMT_EDIT_RIC_CD EQUAL 'F' 3. CLM_TRANS_CD EQUAL '5'  SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'  
3. CLM\_TRANS\_CD EQUAL '6'

SET CLM\_TYPE\_CD TO 41 (OUTPATIENT 'FULL'  
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE  
THE FOLLOWING CONDITIONS ARE MET:

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NAME		TYPE		LENGTH		POSITIONS		CONTENTS	
						BEG	END		
								1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'	
								2. PMT_EDIT_RIC_CD EQUAL 'D'	
								3. CLM_TRANS_CD EQUAL '6'	
								4. FI_NUM = 80881	
								SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'	
								ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)	
								1. FI_NUM = 80881	
								2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_	
								CLSFACTN_TYPE_CD = '2', '3' OR '4' &	
								CLM_FREQ_CD = 'Z', 'Y' OR 'X'	
								SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)	
								WHERE THE FOLLOWING CONDITIONS ARE MET:	
								1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'	
								2. PMT_EDIT_RIC_CD EQUAL 'I'	
								3. CLM_TRANS_CD EQUAL 'H'	
								SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)	
								WHERE THE FOLLOWING CONDITIONS ARE MET:	
								1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'	
								2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'	
								3. CLM_TRANS_CD EQUAL '1' '2' OR '3'	
								SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER	
								CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -	
								12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:	

1. CLM\_MCO\_PD\_SW = '1'  
2. CLM\_RLT\_COND\_CD = '04'  
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET\_CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE  
FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'  
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (INPATIENT 'ABBREVIATED'  
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE  
THE FOLLOWING CONDITIONS ARE MET:  
1. FI\_NUM = 80881 AND  
2. CLM\_FAC\_TYPE\_CD = '1'; CLM\_SRVC\_CLSFCTN\_  
TYPE\_CD = '1'; CLM\_FREQ\_CD = 'Z'

SET CLM\_TYPE\_CD TO 71 (RIC O non-DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'

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		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG  END	
-----				
				2.    HCPCS_CD not on DMEPOS table
				SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
				1.    CLM_NEAR_LINE_RIC_CD EQUAL 'O'
				2.    HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).
				SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:
				1.    CARR_NUM = 80882 AND
				2.    CLM_DEMO_ID_NUM = 38
				SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)
				WHERE THE FOLLOWING CONDITIONS ARE MET:
				1.    CLM_NEAR_LINE_RIC_CD EQUAL 'M'
				2.    HCPCS_CD not on DMEPOS table
				SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
				1.    CLM_NEAR_LINE_RIC_CD EQUAL 'M'
				2.    HCPCS_CD on DMEPOS table (NOTE: if one or

more line item(s) match the HCPCS on the DMEPOS table).

CODES:  
REFER TO: NCH\_CLM\_TYPE\_TB  
IN THE CODES APPENDIX

SOURCE:  
NCH

6. Claim Related Condition CHAR 2 22 23 The code that indicates a condition relating to an institutional claim that may affect payer processing.

DB2 ALIAS: CLM\_RLT\_COND\_CD  
SAS ALIAS: RLT\_COND  
STANDARD ALIAS: CLM\_RLT\_COND\_CD  
SYSTEM ALIAS: LTCOND  
TITLE ALIAS: RELATED\_CONDITION\_CD

CODES:  
01 THRU 16 = Insurance related  
17 THRU 30 = Special condition  
31 THRU 35 = Student status codes which are required when a patient is a dependent child over 18 years old  
36 THRU 45 = Accommodation  
46 THRU 54 = CHAMPUS information  
55 THRU 59 = Skilled nursing facility

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG END	
-----	----	-----	-----	-----
				60 THRU 70 = Prospective payment 71 THRU 99 = Renal dialysis setting A0 THRU B9 = Special program codes C0 THRU C9 = PRO approval services D0 THRU W0 = Change conditions

CODES:  
REFER TO: CLM\_RLT\_COND\_TB  
IN THE CODES APPENDIX  
SOURCE:  
CWF

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

\*\*\*\*\*  
C L A I M R E L A T E D O C C U R R E N C E G R O U P R E C O R D  
\*\*\*\*\*

POSITIONS

NAME		TYPE	LENGTH	BEG	END	CONTENTS
-----		----	-----	-----	-----	-----
****	FI Inpatient/Skilled Nursing Facility Claim Related Occurrence Group Record - Encrypted Standard View	GROUP	31			<p>Claim Related Occurrence Group Record for the Standard Encrypted View of the Inpatient/SNF files version I NCH Nearline File.</p> <p>The number of claim related occurrence trailers is determined by the claim related occurrence code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.</p> <p>OCCURS: UP TO 30 TIMES DEPENDING ON IP_CLM_RLT_OCRNC_CD_CNT</p> <p>STANDARD ALIAS: UTLIPSNI_CLM_RLT_OCRNC_GRP</p>
1.	Record Length Count	NUM	5	1	5	<p>The length of the Claim Related Occurrence Group Record.</p> <p>5 DIGITS UNSIGNED</p> <p>STANDARD ALIAS: TRAIL_BYTE_COUNT</p>
2.	Record Number	NUM	9	6	14	<p>A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim.</p> <p>STANDARD ALIAS: TRAIL_CLAIM_NO</p>
3.	Record Type	NUM	2	15	16	<p>Type of Record.</p> <p>STANDARD ALIAS: TRAIL_REC_TYPE</p> <p>CODES:</p> <p>00 = Fixed/Main Group 01 = Carrier Line Group 02 = Claim Demonstration ID Group 03 = ClaimDiagnosis Group 04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group 10 = MCO Period Group</p>
1	FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002					
NAME		TYPE	LENGTH	BEG	END	CONTENTS
-----		----	-----	-----	-----	-----
						<p>11 = NCH Edit Group 12 = NCH Patch Group</p>

					13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim.  STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH.  NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991).  NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.  STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD  DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM  INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT  INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM  INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS				
NAME	TYPE	LENGTH	BEG	END	CONTENTS	
-----	----	-----	-----	-----	-----	

NOTE: From 7/1/97 to the start of HDC processing(?),

abbreviated inpatient encounter claims are not available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(AVAILABLE IN NMUD)  
CARR\_NUM  
CLM\_DEMO\_ID\_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(AVAILABLE IN NMUD)  
FI\_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE  
DERIVED FROM: (AVAILABLE IN NMUD)  
FI\_NUM  
CLM\_FAC\_TYPE\_CD  
CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
CLM\_FREQ\_CD

DERIVATION RULES:

SET CLM\_TYPE\_CD TO 10 (HHA CLAIM) WHERE THE  
FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V','W' OR 'U'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'F'  
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'  
3. CLM\_TRANS\_CD EQUAL '6'

SET CLM\_TYPE\_CD TO 41 (OUTPATIENT 'FULL'  
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE  
THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'

POSITIONS					CONTENTS
NAME	TYPE	LENGTH	BEG	END	

-----

```
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881
```

```
SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
   CLSFCTN_TYPE_CD = '2', '3' OR '4' &
   CLM_FREQ_CD = 'Z', 'Y' OR 'X'
```

```
SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'
```

```
SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
```

```
SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
   MCO_OPTN_CD = 'C'
   CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
   MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
   ENROLLMENT PERIODS
```

```
SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881
```

```
SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
   TYPE_CD = '1'; CLM_FRQ_CD = 'Z'
```

```
SET CLM_TYPE_CD TO 71 (RIC 0 non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table
```

NAME	TYPE	LENGTH	BEG	END	CONTENTS
					SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).  SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CARR_NUM = 80882 AND 2. CLM_DEMO_ID_NUM = 38  SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD not on DMEPOS table  SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).  CODES: REFER TO: NCH_CLM_TYPE_TB  SOURCE: NCH
6. Claim Related Occurrence Code	CHAR	2	22	23	The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date.  DB2 ALIAS: CLM_RLT_OCRNC_CD SAS ALIAS: OCRNC_CD STANDARD ALIAS: CLM_RLT_OCRNC_CD SYSTEM ALIAS: LTOCRNC TITLE ALIAS: OCCURRENCE_CD  CODES: 01 THRU 09 = Accident 10 THRU 19 = Medical condition 20 THRU 39 = Insurance related 40 THRU 69 = Service related A1-A3 = Miscellaneous
1	FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002				

NAME	TYPE	LENGTH	BEG	END	CONTENTS
------	------	--------	-----	-----	----------

					CODES:
					REFER TO: CLM_RLT_OCRNC_TB IN THE CODES APPENDIX
					SOURCE:
					CWF
7.	Claim Related Occurrence Date	NUM	8	24 31	The date associated with a significant event related to an institutional claim that may affect payer processing.
					For the ENCRYPTED Standard View of the Inpatient/SNF files, the claim procedure performed date is coded as the quarter of the calendar year when the procedure was performed.
					8 DIGITS UNSIGNED
					DB2 ALIAS: CLM_RLT_OCRNC_DT SAS ALIAS: OCRNCDT STANDARD ALIAS: CLM_RLT_OCRNC_DT TITLE ALIAS: RLT_OCRNC_DT
					EDIT-RULES FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES. 1 = FIRST QUARTER OF THE CALENDAR YEAR 2 = SECOND QUARTER OF THE CALENDAR YEAR 3 = THIRD QUARTER OF THE CALENDAR YEAR 4 = FOURTH QUARTER OF THE CALENDAR YEAR
					SOURCE:
					CWF
1	FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002				
*****					
C L A I M       V A L U E       G R O U P       R E C O R D					
*****					
NAME		TYPE	LENGTH	POSITIONS BEG    END	CONTENTS
-----		----	-----	-----	-----
****	FI Inpatient/Skilled Nursing Facility Claim Value Group Record - Encrypted Standard View	GROUP	36		Claim Value Group Record for the Encrypted Standard View of the Inpatient/Skilled Nursing Facility version I NCH Nearline File.
					The number of claim value trailers present is determined by the claim

value code count. Effective 10/93,  
up to 36 occurrences can be reported on an  
institutional claim. Prior to 10/93, up  
to 10 occurrences could be reported.

OCCURS: UP TO 36 TIMES  
DEPENDING ON IP\_CLM\_VAL\_CD\_CNT

STANDARD ALIAS: UTLIPSNI\_CLM\_VAL\_GRP

1. Record Length Count	NUM	5	1	5	The length of the Claim Value Group Record.  5 DIGITS UNSIGNED  STANDARD ALIAS: TRAIL_BYTE_COUNT
2. Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim.  STANDARD ALIAS: TRAIL_CLAIM_NO
3. Record Type	NUM	2	15	16	Type of Record.  STANDARD ALIAS: TRAIL_REC_TYPE  CODES: 00 = Fixed/Main Group 01 = Carrier Line Group 02 = Claim Demonstration ID Group 03 = Claim Diagnosis Group 04 = Claim Health PlanID Group 05 = Claim Occurrence Span Group 06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group 10 = MCO Period Group 11 = NCH Edit Group

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS			CONTENTS
NAME	TYPE	LENGTH	BEG	END	
-----					
					12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim.  STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

SYSTEM ALIAS: TRAIL\_NCH\_CLM\_TYPE\_CD

DERIVATION:  
FFS CLAIM TYPE CODES DERIVED FROM:  
NCH CLM\_NEAR\_LINE\_RIC\_CD  
NCH PMT\_EDIT\_RIC\_CD  
NCH CLM\_TRANS\_CD  
NCH PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(Pre-HDC processing -- AVAILABLE IN NCH)  
CLM\_MCO\_PD\_SW  
CLM\_RLT\_COND\_CD  
MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(HDC processing -- AVAILABLE IN NMUD)  
FI\_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)  
FI\_NUM  
CLM\_FAC\_TYPE\_CD  
CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
CLM\_FREQ\_CD

NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG END	
-----				
				PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM
				OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE  
DERIVED FROM: (AVAILABLE IN NMUD)  
FI\_NUM  
CLM\_FAC\_TYPE\_CD  
CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
CLM\_FREQ\_CD

DERIVATION RULES:

SET CLM\_TYPE\_CD TO 10 (HHA CLAIM) WHERE THE  
FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V','W' OR 'U'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'F'  
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'  
3. CLM\_TRANS\_CD EQUAL '6'

SET CLM\_TYPE\_CD TO 41 (OUTPATIENT 'FULL'  
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE  
THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'  
3. CLM\_TRANS\_CD EQUAL '6'  
4. FI\_NUM = 80881

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG END	
-----				
				SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED' ENCOUNTER CLAIMS -- AVAILABLE IN NMUD) 1. FI_NUM = 80881 2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_ CLSFACTN_TYPE_CD = '2', '3' OR '4' & CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM\_TYPE\_CD TO 50 (HOSPICE CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'I'  
3. CLM\_TRANS\_CD EQUAL 'H'

SET CLM\_TYPE\_CD TO 60 (INPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM -- PRIOR TO HDC PROCESSING -- AFTER 6/30/97 -  
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_MCO\_PD\_SW = '1'  
2. CLM\_RLT\_COND\_CD = '04'  
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE  
FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'  
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (INPATIENT 'ABBREVIATED'  
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE  
THE FOLLOWING CONDITIONS ARE MET:  
1. FI\_NUM = 80881 AND  
2. CLM\_FAC\_TYPE\_CD = '1'; CLM\_SRVC\_CLSFCTN\_  
TYPE\_CD = '1'; CLM\_FREQ\_CD = 'Z'

SET CLM\_TYPE\_CD TO 71 (RIC O non-DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL TO '0'  
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 72 (RIC O DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS		
NAME	TYPE	LENGTH	BEG	END
CONTENTS				
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).				
SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING				

CONDITIONS ARE MET:  
1. CARR\_NUM = 80882 AND  
2. CLM\_DEMO\_ID\_NUM = 38

```
SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC  
CLAIM)
```

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 82 (RIC M DMEPOS DMERC CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE RIC\_CD EQUAL 'M'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES :

REFER TO: NCH\_CLM\_TYPE\_TB  
IN THE CODES APPENDIX

SOURCE :

NCH

6. Claim Value Code	CHAR	2	22	23	The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim.
---------------------	------	---	----	----	---

```
DB2 ALIAS: CLM_VAL_CD
SAS ALIAS: VAL_CD
STANDARD ALIAS: CLM_VAL_CD
SYSTEM ALIAS: LTVALUE
TITLE ALIAS: VALUE CD
```

CODES :

REFER TO: CLM\_VAL\_TB  
IN THE CODES APPENDIX

SOURCE :

CWF

7. Claim Value Amount	CHAR	13	24	36	The amount related to the condition identified in the CLM_VAL_CD which was used by the intermediary to process the institutional claim.
-----------------------	------	----	----	----	---

## 9.2 DIGITS SIGNED

```
1      FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002
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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					DB2 ALIAS: CLM_VAL_AMT
					SAS ALIAS: VAL_AMT
					STANDARD ALIAS: CLM_VAL_AMT
					TITLE ALIAS: VALUE AMOUNT

EDIT-RULES:  
+9(9).99

SOURCE:  
CWF

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

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C L A I M R E V E N U E C E N T E R G R O U P R E C O R D

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		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG END	
-----	----	-----	-----	-----
**** FI Inpatient/Skilled Nursing Facility Claim Revenue Center Group Record - Encrypted Standard View	GROUP	262		<p>Claim Revenue Center Group Record for the Encrypted Standard View of the Inpatient/Skilled Nursing Facility version I Nearline File.</p> <p>The number of claim revenue center group trailers present is determined by the claim revenue center code count. Effective 7/7/00, up to 450 occurrences may be reported for an institutional claim. The increase in the number of revenue center lines causes each claim to be broken out into records/segments (up to 10). Each record can have up to 45 occurrences of revenue center lines. Prior to 7/7/00, up to 58 occurrences may be reported on an institutional claim. Claims submitted prior to 10/93, contained up to 28 occurrences.</p> <p>OCCURS: UP TO 45 TIMES</p> <p>STANDARD ALIAS: UTLIPSNI_CLM_REV_CNTR_GRP</p> <p>COMMENT: ***** FOR SNF PPS ***** The Balanced Budget Act modified how payment will be made for skilled nursing facility (SNF) services. Effective with cost reporting periods beginning on or after 7/1/98 (with all providers transitioning by 6/30/99, SNFs will be paid on a prospective payment system (PPS)).</p> <p>SNFs will classify beneficiaries on the basis of residents' characteristics and resource needs, using the 44-group patient classification system known as Resource Utilization Groups (RUGS), Version III. Facilities will use information from the Minimum Data Set (MDS), Version 2.0, Resident Assessment Instrument</p>

(RAI) to classify residents into the RUG-III groups.

\*\*\*\*\* FOR OUTPATIENT PPS \*\*\*\*\*

The Balanced Budget Act modified how payment will be made for hospital outpatient services, certain PTB services furnished to inpatients who have no PTA coverage, CMHCs, and limited services provided by

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		POSITIONS			CONTENTS
NAME	TYPE	LENGTH	BEG	END	
-----					
					CORFs, Home Health Agencies or to hospice patients for the treatment of a non-terminal illness. Implementation for Outpatient PPS (OPPS) will be effective for claims with dates of service on or after July 1, 2000.
					Payment for services under the OPPS system is calculated based on grouping outpatient services into ambulatory payment classifications (APC) groups.
					***** FOR HOME HEALTH PPS *****
					The Balanced Budget Act of 1997 mandated changes in payment and other provider requirements for home health. All home health agencies will be paid through a prospective payment system beginning October 1, 2000.
					Under Home Health PPS (HH PPS) the unit of payment will be a 60-day episode. Home Health Resources Groups (HHRGs), also called HRGs represented by HCFA HIPPS coding, will be the basis of payment for each episode; HHRGs will be produced through publicly available Grouper software that will determine the appropriate HHRG when results of comprehensive assessments of the beneficiary (made incorporating the OASIS data set) are input or grouped in this software.
1. Record Length Count	NUM	5	1	5	The length of the Claim Revenue Center Group Record.
					5 DIGITS UNSIGNED
					STANDARD ALIAS: TRAIL_BYTE_COUNT
2. Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim.
					STANDARD ALIAS: TRAIL_CLAIM_NO
3. Record Type	NUM	2	15	16	Type of Record.
					STANDARD ALIAS: TRAIL_REC_TYPE

CODES:  
00 = Fixed/Main Group  
01 = Carrier Line Group  
02 = Claim Demonstration ID Group  
03 = Claim Diagnosis Group  
04 = Claim Health PlanID Group  
05 = Claim Occurrence Span Group

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					06 = Claim Procedure Group 07 = Claim Related Condition Group 08 = Claim Related Occurrence Group 09 = Claim Value Group 10 = MCO Period Group 11 = NCH Edit Group 12 = NCH Patch Group 13 = DMERC Line Group 14 = Revenue Center Group
4. Claim Sequence Number	NUM	3	17	19	A counter for records that consist of trailer information, such as claim line and revenue center data, which can occur multiple times for one claim.  STANDARD ALIAS: TRAIL_CLAIM_SEQ
5. NCH Claim Type Code	CHAR	2	20	21	The code used to identify the type of claim record being processed in NCH.  NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991).  NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.  STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD  DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM: NCH CLM_NEAR_LINE_RIC_CD NCH PMT_EDIT_RIC_CD NCH CLM_TRANS_CD NCH PRVDR_NUM  INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW CLM_RLT_COND_CD MCO_CNTRCT_NUM

MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(HDC processing -- AVAILABLE IN NMUD)  
FI\_NUM

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
-----					
					INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)
					FI_NUM
					CLM_FAC_TYPE_CD
					CLM_SRVC_CLSFCTN_TYPE_CD
					CLM_FREQ_CD
					NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.
					PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD)
					CARR_NUM
					CLM_DEMO_ID_NUM
					OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD)
					FI_NUM
					OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD)
					FI_NUM
					CLM_FAC_TYPE_CD
					CLM_SRVC_CLSFCTN_TYPE_CD
					CLM_FREQ_CD
					DERIVATION RULES:
					SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
					1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
					2. PMT_EDIT_RIC_CD EQUAL 'F'
					3. CLM_TRANS_CD EQUAL '5'
					SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
					1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
					2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
					3. CLM_TRANS_CD EQUAL '0' OR '4'
					4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y' OR 'Z'
					SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

- 1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
- 2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
- 3. CLM\_TRANS\_CD EQUAL '0' OR '4'
- 4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y' OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
					2. PMT_EDIT_RIC_CD EQUAL 'D'
					3. CLM_TRANS_CD EQUAL '6'
					SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
					ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
					THE FOLLOWING CONDITIONS ARE MET:
					1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
					2. PMT_EDIT_RIC_CD EQUAL 'D'
					3. CLM_TRANS_CD EQUAL '6'
					4. FI_NUM = 80881
					SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
					ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
					1. FI_NUM = 80881
					2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
					CLSFACTN_TYPE_CD = '2', '3' OR '4' &
					CLM_FREQ_CD = 'Z', 'Y' OR 'X'
					SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
					WHERE THE FOLLOWING CONDITIONS ARE MET:
					1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
					2. PMT_EDIT_RIC_CD EQUAL 'I'
					3. CLM_TRANS_CD EQUAL 'H'
					SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
					WHERE THE FOLLOWING CONDITIONS ARE MET:
					1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
					2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
					3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
					SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
					CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
					12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
					1. CLM_MCO_PD_SW = '1'
					2. CLM_RLT_COND_CD = '04'
					3. MCO_CNTRCT_NUM
					MCO_OPTN_CD = 'C'
					CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
					MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
					ENROLLMENT PERIODS
					SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER

CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:

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		POSITIONS				CONTENTS	
NAME	TYPE	LENGTH	BEG	END			
						1. FI_NUM = 80881 AND	
						2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_TYPE_CD = '1'; CLM_FREQ_CD = 'Z'	
						SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:	
						1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'	
						2. HCPCS_CD not on DMEPOS table	
						SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:	
						1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'	
						2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).	
						SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:	
						1. CARR_NUM = 80882 AND	
						2. CLM_DEMO_ID_NUM = 38	
						SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:	
						1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'	
						2. HCPCS_CD not on DMEPOS table	
						SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:	
						1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'	
						2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).	
						CODES:	
						REFER TO: NCH_CLM_TYPE_TB	
						IN THE CODES APPENDIX	
						SOURCE:	
						NCH	

6. Revenue Center Code

CHAR

4

22

25

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

COBOL ALIAS: REV\_CD  
DB2 ALIAS: REV\_CNTR\_CD  
SAS ALIAS: REV\_CNTR  
STANDARD ALIAS: REV\_CNTR\_CD

1

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			POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG	END	
-----					
SYSTEM ALIAS: LTRC					
TITLE ALIAS: REVENUE_CENTER_CD					
CODES:					
REFER TO: REV_CNTR_TB					
IN THE CODES APPENDIX					
SOURCE:					
CWF					

7. Revenue Center Date

NUM

8

26

33

Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.

For the ENCRYPTED Standard View of the Inpatient/ SNF files, the date applicable to the service represented by the revenue center code is coded as the quarter of the calendar year when the service represented by the revenue center code occurred.

NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must

represent the first date of service in the episode.  
The final claim will match the '0023' information  
submitted on the initial claim. The SCIC  
(significant change in condition) claims may show  
additional '0023' revenue lines in which the  
date represents the date of the first service  
under the revised plan of treatment.

8 DIGITS UNSIGNED

DB2 ALIAS: REV\_CNTR\_DT  
SAS ALIAS: REV\_DT  
STANDARD ALIAS: REV\_CNTR\_DT  
TITLE ALIAS: REV\_CNTR\_DATE

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NAME		TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
						EDIT-RULES FOR ENCRYPTED DATA: YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES. 1 = FIRST QUARTER OF THE CALENDAR YEAR 2 = SECOND QUARTER OF THE CALENDAR YEAR 3 = THIRD QUARTER OF THE CALENDAR YEAR 4 = FOURTH QUARTER OF THE CALENDAR YEAR  SOURCE: CWF
8. Revenue Center APC/HIPPS Code		CHAR	5	34	38	Effective with Outpatient PPS (OPPS), the Ambulatory Payment Classification (APC) code used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS.  Effective with Home Health PPS (HHPPS), this field will only be populated with a HIPPS code if the HIPPS code that is stored in the HCPCS field has been downcoded and the new code will be placed in this field.  NOTE1: Under SNF PPS and HHPPS, HIPPS codes are stored in the HCPCS field. **EXCEPTION: if a HHPPS HIPPS code is downcoded the downcoded HIPPS will be stored in this field.  NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.  DB2 ALIAS: REV_APC_HIPPS_CD SAS ALIAS: APCHIPPS STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD SYSTEM ALIAS: LTAPC

TITLE ALIAS: APC\_HIPPS

CODES:

REFER TO: REV\_CNTR\_APC\_TB

IN THE CODES APPENDIX

SOURCE:

CWF

9.	Revenue Center HCFA Common Procedure Coding System Code	CHAR	5	39	43	HCFA's Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below:
1	FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002					
NAME		TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
						DB2 ALIAS: REV_CNTR_HCPCS_CD SAS ALIAS: HCPCS_CD STANDARD ALIAS: REV_CNTR_HCPCS_CD SYSTEM ALIAS: LTHIPPS TITLE ALIAS: HCPCS_CD
						CODES: REFER TO: CLM_HIPPS_TB IN THE CODES APPENDIX
						COMMENT: Prior to Version H this field was named: HCPCS_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and non-institutional: LINE).
						NOTE: When revenue center code = '0022' (SNF PPS) or '0023' (HH PPS), this field contains the Health Insurance PPS (HIPPS) code. The HIPPS code for SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.
						The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented bythe HIPPS coding, will be the basis of payment for each episode.

For both SNF PPS & HH PPS HIPPS values see CLM\_HIPPS\_TB.

Level I  
Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services.

\*\*\*\* Note: \*\*\*\*  
CPT-4 codes including both long and short descriptions shall be used in accordance with the HCFA/AMA agreement. Any other use violates the AMA copyright.

Level II  
Includes codes and descriptors copyrighted by the American Dental Association's Current Dental

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		POSITIONS			CONTENTS
NAME	TYPE	LENGTH	BEG	END	
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Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Level III  
Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

10. Revenue Center HCPCS CHAR 2 44 45 A first modifier to the procedure code to enable a more specific procedure identification for the claim.

DB2 ALIAS: REV\_HCPCS\_MDFR\_CD  
SAS ALIAS: MDFR\_CD1  
STANDARD ALIAS: REV\_CNTR\_HCPCS\_INITL\_MDFR\_CD  
TITLE ALIAS: INITIAL\_MODIFIER

EDIT-RULES:  
Carrier Information File

COMMENT:  
Prior to Version H this field was named:

HCPCS\_INITL\_MDRFR\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

SOURCE:  
CWF

11. Revenue Center HCPCS Second Modifier Code

A second modifier to the procedure code to make it more specific than the first modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV\_HCPCS\_2ND\_CD  
SAS ALIAS: MDRFR\_CD2  
STANDARD ALIAS: REV\_CNTR\_HCPCS\_2ND\_MDRFR\_CD  
TITLE ALIAS: SECOND\_MODIFIER

EDIT-RULES:  
CARRIER INFORMATION FILE

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		POSITIONS			CONTENTS
NAME	TYPE	LENGTH	BEG	END	
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COMMENT:  
Prior to Version H this field was named: HCPCS\_2ND\_MDRFR\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

SOURCE:  
CWF

12. Revenue Center HCPCS Third Modifier Code

Effective with Version I, a third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV\_HCPCS\_3RD\_CD  
SAS ALIAS: MDRFR\_CD3  
STANDARD ALIAS: REV\_CNTR\_HCPCS\_3RD\_MDRFR\_CD  
TITLE ALIAS: THIRD\_MODIFIER

EDIT-RULES:  
CARRIER INFORMATION FILE

COMMENT:  
NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE:  
CWF

13. Revenue Center HCPCS Fourth Modifier Code

CHAR25051

Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV\_HCPCS\_4TH\_CD  
SAS ALIAS: MDFR\_CD4  
STANDARD ALIAS: REV\_CNTR\_HCPCS\_4TH\_MDFR\_CD  
TITLE ALIAS: FOURTH\_MODIFIER

EDIT-RULES:  
CARRIER INFORMATION FILE

COMMENT:  
NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE:  
CWF

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NAME		TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
-----		----	-----	-----	-----	-----
14. Revenue Center HCPCS Fifth Modifier Code	CHAR	2	52	53	Effective with Version I, a fifth modifier to the procedure code to make it more specific than the fourth modifier code to identify the procedures performed on the beneficiary for the claim.	
					DB2 ALIAS: REV_HCPCS_5TH_CD	
					SAS ALIAS: MDFR_CD5	
					STANDARD ALIAS: REV_CNTR_HCPCS_5TH_MDFR_CD	
					TITLE ALIAS: FIFTH_MODIFIER	
					EDIT-RULES: CARRIER INFORMATION FILE	
					COMMENT: NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.	
					SOURCE: CWF	
15. Revenue Center Payment Method Indicator Code	CHAR	2	54	55	Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator.	
					NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data.	

Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV\_PMT\_MTHD\_CD  
SAS ALIAS: PMTMTHD  
STANDARD ALIAS: REV\_CNTR\_PMT\_MTHD\_IND\_CD  
SYSTEM ALIAS: LTPMTHD  
TITLE ALIAS: PMT\_MTHD

CODES:  
REFER TO: REV\_CNTR\_PMT\_MTHD\_IND\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

16. Revenue Center Discount Indicator Code

CHAR15656

Effective with Version 'I', for all services subject to Outpatient PPS, this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV\_CNTR\_PMT\_MTHD\_IND\_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. \*\*If there is no dis-

1

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NAME		TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END		
						counting the factor will be 1.0.**
						NOTE1: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.
						DB2 ALIAS: REV_DSCNT_IND_CD
						SAS ALIAS: DSCNTIND
						STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD
						SYSTEM ALIAS: LTDSCNT
						TITLE ALIAS: REV_CNTR_DSCNT_IND_CD
						CODES:
						*DISCOUNTING FORMULAS*
						1 = 1.0
						2 = (1.0+D(U-1)) /U
						3 = T/U
						4 = (1+D) /U
						5 = D
						6 = TD/U
						7 = D(1+D) /U
						8 = 2.0/U
						SOURCE:
						CWF

17. Revenue Center Packaging Indicator Code

CHAR15757

Effective with Version 'I', for all services subject to Outpatient PPS, the code used to identify those services that are packaged/ bundled with another service.

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV\_PACKG\_IND\_CD  
SAS ALIAS: PACKGIND  
STANDARD ALIAS: REV\_CNTR\_PACKG\_IND\_CD  
SYSTEM ALIAS: LTPACKG  
TITLE ALIAS: REV\_CNTR\_PACKG\_IND

CODES:  
0 = Not packaged  
1 = Packaged service (service indicator N)  
2 = Packaged as part of partial hospitalization per diem or daily mental health service per diem

SOURCE:  
CWF

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NAME		TYPE	LENGTH	POSITIONS		CONTENTS
-----				BEG	END	
-----		----	-----	-----	-----	-----
18.	Revenue Center Pricing Indicator Code	CHAR	2	58	59	Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount.  NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.  DB2 ALIAS: REV_PRICNG_IND_CD SAS ALIAS: PRICNG STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD SYSTEM ALIAS: LTPRICNG TITLE ALIAS: REV_CNTR_PRICNG_IND  CODES: REFER TO: REV_CNTR_PRICNG_IND_TB IN THE CODES APPENDIX  SOURCE: CWF
19.	Revenue Center Obligation to Accept As Full (OTAF) Payment Code	CHAR	1	60	60	Effective with Version 'I' the code used to indicate that the provider was obligated to accept as full payment the amount re-

ceived from the primary (or secondary) payer.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.  
DB2 ALIAS: REV\_OTAF1\_IND\_CD  
SAS ALIAS: OTAF\_1  
STANDARD ALIAS: REV\_CNTR\_OTAF\_1\_IND\_CD  
TITLE ALIAS: REV\_CNTR\_OTAF\_1\_IND\_CD

EDIT-RULES:  
Y = provider is obligated to accept the payment as payment in full for the service.  
N or blank = provider is not obligated to accept the payment, or there is no payment by a prior payer.

SOURCE:  
CWF

20. Revenue Center IDE, NDC, CHAR 24 61 84 Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was

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		POSITIONS		CONTENTS
NAME	TYPE	LENGTH	BEG  END	
-----				
				implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95.  IDE's are always associated with revenue center code '0624'.
				NOTE1:  Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's.  The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'.  There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer.  During the Version H conversion IDE's were moved from the dummy '0624' trailer to this dedicated field.
				NOTE2:  Effective with Version 'I', this field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC).  This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim).  The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7)).  DATA ANAMOLY/LIMITATION:  During an CWFMQA review an edit revealed the IDE was missing.

The problem occurs in claim with an NCH weekly process dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.

DB2 ALIAS: IDE\_NDC\_UPC\_NUM  
SAS ALIAS: IDENDC  
STANDARD ALIAS: REV\_CNTR\_IDE\_NDC\_UPC\_NUM  
TITLE ALIAS: IDE\_NDC\_UPC

SOURCE:  
CWF

21. Revenue Center Unit Count CHAR 8 85 92 A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPSC code definition as described on an institutional claim.

Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of

blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.

NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
-----	----	-----	-----	-----	-----

7 DIGITS SIGNED

DB2 ALIAS: REV\_CNTR\_UNIT\_CNT  
SAS ALIAS: REV\_UNIT  
STANDARD ALIAS: REV\_CNTR\_UNIT\_CNT  
TITLE ALIAS: UNITS

EDIT-RULES:  
+9(7)

SOURCE:  
CWF

22. Revenue Center Rate Amount CHAR 13 93 105 Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, \$1 will be reported in the field.

NOTE1: For SNF PPS claims (when revenue center code equals '0022'), HCFA has developed a SNF PRICER to compute the rate based on the provider

supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

NOTE2: For OP PPS claims, HCFA has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

NOTE3: Under HH PPS (when revenue center code equals '0023'), HCFA has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_CNTR\_RATE\_AMT  
SAS ALIAS: REV\_RATE

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS			CONTENTS
NAME	TYPE	LENGTH	BEG	END	
-----					
STANDARD ALIAS: REV_CNTR_RATE_AMT					
TITLE ALIAS: CHARGE_PER_UNIT					
EDIT-RULES:					
+9(9).99					
EFFECTIVE-DATE: 10/01/1993					
COMMENT:					
Prior to Version H the size of this field was:					
S9(7)V99.					
SOURCE:					
CWF					
23. Revenue Center Blood Deductible Amount	CHAR	13	106	118	Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible for the line item service.
NOTE: Beginning with NCH weekly process date					

## 9.2 DIGITS SIGNED

EDIT-RULES:  
+9 (9) .99

24. Revenue Center Cash	CHAR	13	119	131	Effective with Version 'I' the amount of cash
Deductible Amount					deductible the beneficiary paid for the line
					item service.

## 9.2 DIGITS SIGNED

```
1      FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002
```

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					EDIT-RULES: +9(9).99  SOURCE: CWF
25. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount	CHAR	13	132	144	Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.  NOTE1: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted.

The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: ADJSTD\_COINSRNC  
SAS ALIAS: WAGEADJ  
STANDARD ALIAS: REV\_CNTR\_WAGE\_ADJSTD\_COINS\_AMT  
TITLE ALIAS: WAGE\_ADJSTD\_COINS

EDIT-RULES:  
+9(9).99

SOURCE:  
CWF

26. Revenue Center Reduced Coinsurance Amount

CHAR13145157

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

NOTE1: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain

1

FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

NAME		TYPE		LENGTH		POSITIONS		CONTENTS
						BEG	END	
-----		----		-----				-----

spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: RDCD\_COINSRNC  
SAS ALIAS: RDCDCOIN  
STANDARD ALIAS: REV\_CNTR\_RDCD\_COINS\_AMT  
TITLE ALIAS: REDUCED\_COINS

EDIT-RULES:  
+9(9).99

SOURCE:  
CWF

27. Revenue Center 1st Medicare

CHAR13158170

Effective with Version 'I', the amount paid by

Secondary Payer Paid  
Amount

the primary payer when the payer is primary to  
Medicare (Medicare is secondary or tertiary).

NOTE: Beginning with NCH weekly process date  
7/7/00, this field will be populated with data.  
Claims processed prior to 7/7/00 will contain  
spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_MSP1\_PD\_AMT  
SAS ALIAS: REV\_MSP1  
STANDARD ALIAS: REV\_CNTR\_MSP1\_PD\_AMT  
TITLE ALIAS: MSP PAID AMOUNT

EDIT-RULES:  
+9(9).99

SOURCE:  
CWF

28. Revenue Center 2nd Medicare CHAR 13 171 183  
Secondary Payer Paid  
Amount

Effective with Version 'I', the amount paid by  
the secondary payer when two payers are primary  
to Medicare (Medicare is the tertiary payer).

NOTE: Beginning with NCH weekly process date  
7/7/00, this field will be populated with data.  
Claims processed prior to 7/7/00 will contain  
spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_MSP2\_PD\_AMT  
SAS ALIAS: REV\_MSP2  
STANDARD ALIAS: REV\_CNTR\_MSP2\_PD\_AMT  
TITLE ALIAS: MSP PAID AMOUNT

1 FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS			CONTENTS
NAME	TYPE	LENGTH	BEG	END	
-----	----	-----	-----	-----	-----

EDIT-RULES:  
+9(9).99

SOURCE:  
CWF

29. Revenue Center Provider CHAR 13 184 196  
Payment Amount

Effective with Version 'I', the amount paid  
to the provider for the services reported  
on the line item.

NOTE: Beginning with NCH weekly process date  
7/7/00, this field will be populated with data.  
Claims processed prior to 7/7/00 will contain  
spaces in this field.

```
DB2 ALIAS: REV_PRVDR_PMT_AMT
SAS ALIAS: RPRVDPMT
STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT
TITLE ALIAS: REV_PRVDR_PMT
```

SOURCE :  
CWF

Effective with Version I, the amount paid to the beneficiary for the services reported on the line item.

```
DB2 ALIAS: REV_BENE_PMT_AMT
SAS ALIAS: RBENEPMT
STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT
TITLE ALIAS: REV_BENE_PMT
```

SOURCE :  
CWF

Effective with Version I, the amount paid by the beneficiary to the provider for the line item service.

## POSITIONS

```
DB2 ALIAS: REV_PTNT_RESP_AMT
SAS ALIAS: PTNTRESP
STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT
TITLE ALIAS: REV_PTNT_RESP
```

EDIT-RULES:

						+9(9).99
						SOURCE: CWF
32.	Revenue Center Payment Amount	CHAR	13	223	235	Effective with Version 'I', the line item Medicare payment amount for the specific revenue center.  Under OP PPS, PRICER will compute the standard OPPS payment for a line item based on the payment APC.  Under OP PPS, PRICER will compute the standard OPPS payment for a line item based on the payment APC.  Under HH PPS, PRICER will compute/return a line item payment amount for the case-mixed, wage-index adjusted HIPPS code assigned to the '0023' revenue center line. The HIPPS code will be stored in the Revenue Center HCPCS code field.  9.2 DIGITS SIGNED  COMMON ALIAS: REIMBURSEMENT DB2 ALIAS: REV_CNTR_PMT_AMT SAS ALIAS: REVPMT STANDARD ALIAS: REV_CNTR_PMT_AMT TITLE ALIAS: REIMBURSEMENT  EDIT-RULES: +9(9).99  SOURCE: CWF
33.	Revenue Center Total Charge Amount	CHAR	13	236	248	The total charges (covered and non-covered) for all accommodations and services (related to the revenue code)
1	FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002					
	NAME	TYPE	LENGTH	POSITIONS BEG END		CONTENTS
	-----	----	-----	-----		-----
						for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).  EXCEPTIONS: (1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the

demo).

(2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.

(4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').

(5) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be \$1 (rate) times units (days).

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_TOT\_CHRG\_AMT  
SAS ALIAS: REV\_CHRG  
STANDARD ALIAS: REV\_CNTR\_TOT\_CHRG\_AMT  
TITLE ALIAS: REVENUE\_CENTER\_CHARGES

EDIT-RULES:  
+9(9).99

COMMENT:  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE:  
CWF

34. Revenue Center Non-Covered Charge Amount

CHAR13249261

The charge amount related to a revenue center code for services that are not covered by Medicare.

NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format. As of NCH weekly process date 10/3/97 this field was added to all institutional claim types.

9.2 DIGITS SIGNED

1

FI Inpatient SNF Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

		POSITIONS		
NAME	TYPE	LENGTH	BEG	END
-----	----	-----	-----	-----
DB2 ALIAS: REV_NCVR_CHRG_AMT SAS ALIAS: REV_NCVR STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES				
EDIT-RULES: +9(9).99				

					SOURCE: CWF
35. Revenue Center Deductible Coinsurance Code	CHAR	1	262	262	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.
					DB2 ALIAS: DDCTBL_COINSRNC_CD SAS ALIAS: REVDEDCD STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD
					CODES: REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB IN THE CODES APPENDIX
					SOURCE: CWF

1

BENE\_IDENT\_TB

Beneficiary Identification Code (BIC) Table

-----

Social Security Administration:

A = Primary claimant  
B = Aged wife, age 62 or over (1st claimant)  
B1 = Aged husband, age 62 or over (1st claimant)  
B2 = Young wife, with a child in her care (1st claimant)  
B3 = Aged wife (2nd claimant)  
B4 = Aged husband (2nd claimant)  
B5 = Young wife (2nd claimant)  
B6 = Divorced wife, age 62 or over (1st claimant)  
B7 = Young wife (3rd claimant)  
B8 = Aged wife (3rd claimant)  
B9 = Divorced wife (2nd claimant)  
BA = Aged wife (4th claimant)  
BD = Aged wife (5th claimant)  
BG = Aged husband (3rd claimant)  
BH = Aged husband (4th claimant)  
BJ = Aged husband (5th claimant)  
BK = Young wife (4th claimant)  
BL = Young wife (5th claimant)  
BN = Divorced wife (3rd claimant)  
BP = Divorced wife (4th claimant)  
BQ = Divorced wife (5th claimant)  
BR = Divorced husband (1st claimant)  
BT = Divorced husband (2nd claimant)  
BW = Young husband (2nd claimant)  
BY = Young husband (1st claimant)  
C1-C9,CA-CZ = Child (includes minor, student or disabled child)  
D = Aged widow, 60 or over (1st claimant)  
D1 = Aged widower, age 60 or over (1st claimant)  
D2 = Aged widow (2nd claimant)

D3 = Aged widower (2nd claimant)  
D4 = Widow (remarried after attainment of  
age 60) (1st claimant)  
D5 = Widower (remarried after attainment of  
age 60) (1st claimant)  
D6 = Surviving divorced wife, age 60 or over  
(1st claimant)  
D7 = Surviving divorced wife (2nd claimant)  
D8 = Aged widow (3rd claimant)  
D9 = Remarried widow (2nd claimant)  
DA = Remarried widow (3rd claimant)  
DC = Surviving divorced husband (1st claimant)  
DD = Aged widow (4th claimant)  
DG = Aged widow (5th claimant)  
DH = Aged widower (3rd claimant)  
DJ = Aged widower (4th claimant)  
DK = Aged widower (5th claimant)  
DL = Remarried widow (4th claimant)  
DM = Surviving divorced husband (2nd claimant)  
DN = Remarried widow (5th claimant)

1

BENE\_IDENT\_TB

Beneficiary Identification Code (BIC) Table

DP = Remarried widower (2nd claimant)  
DQ = Remarried widower (3rd claimant)  
DR = Remarried widower (4th claimant)  
DS = Surviving divorced husband (3rd  
claimant)  
DT = Remarried widower (5th claimant)  
DV = Surviving divorced wife (3rd claimant)  
DW = Surviving divorced wife (4th claimant)  
DX = Surviving divorced husband (4th  
claimant)  
DY = Surviving divorced wife (5th claimant)  
DZ = Surviving divorced husband (5th  
claimant)  
E = Mother (widow) (1st claimant)  
E1 = Surviving divorced mother (1st  
claimant)  
E2 = Mother (widow) (2nd claimant)  
E3 = Surviving divorced mother (2nd  
claimant)  
E4 = Father (widower) (1st claimant)  
E5 = Surviving divorced father (widower)  
(1st claimant)  
E6 = Father (widower) (2nd claimant)  
E7 = Mother (widow) (3rd claimant)  
E8 = Mother (widow) (4th claimant)  
E9 = Surviving divorced father (widower)  
(2nd claimant)  
EA = Mother (widow) (5th claimant)  
EB = Surviving divorced mother (3rd  
claimant)  
EC = Surviving divorced mother (4th  
claimant)  
ED = Surviving divorced mother (5th  
claimant)

EF = Father (widower) (3rd claimant)  
EG = Father (widower) (4th claimant)  
EH = Father (widower) (5th claimant)  
EJ = Surviving divorced father (3rd claimant)  
EK = Surviving divorced father (4th claimant)  
EM = Surviving divorced father (5th claimant)  
F1 = Father  
F2 = Mother  
F3 = Stepfather  
F4 = Stepmother  
F5 = Adopting father  
F6 = Adopting mother  
F7 = Second alleged father  
F8 = Second alleged mother  
J1 = Primary prouty entitled to HIB (less than 3 Q.C.) (general fund)  
J2 = Primary prouty entitled to HIB (over 2 Q.C.) (RSI trust fund)  
J3 = Primary prouty not entitled to HIB (less than 3 Q.C.) (general fund)  
J4 = Primary prouty not entitled to HIB  
Beneficiary Identification Code (BIC) Table  
-----  
  
(over 2 Q.C.) (RSI trust fund)  
K1 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)  
K2 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)  
K3 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)  
K4 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)  
K5 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)  
K6 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)  
K7 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)  
K8 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)  
K9 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)  
KA = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)  
KB = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)  
KC = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)

KD = Prouty wife entitled to HIB (less than  
3 Q.C.) (general fund) (4th claimant)  
KE = Prouty wife entitled to HIB (over 2 Q.C  
(4th claimant)  
KF = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (4th claimant)  
KG = Prouty wife not entitled to HIB (over  
2 Q.C.) (4th claimant)  
KH = Prouty wife entitled to HIB (less than  
3 Q.C.) (5th claimant)  
KJ = Prouty wife entitled to HIB (over 2  
Q.C.) (5th claimant)  
KL = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (5th claimant)  
KM = Prouty wife not entitled to HIB (over  
2 Q.C.) (5th claimant)  
M = Uninsured-not qualified for deemed HIB  
M1 = Uninsured-qualified but refused HIB  
T = Uninsured-entitled to HIB under deemed  
or renal provisions  
TA = MQGE (primary claimant)  
TB = MQGE aged spouse (first claimant)  
TC = MQGE disabled adult child (first claimant)  
TD = MQGE aged widow(er) (first claimant)  
TE = MQGE young widow(er) (first claimant)  
TF = MQGE parent (male)  
TG = MQGE aged spouse (second claimant)  
Beneficiary Identification Code (BIC) Table  
-----  
TH = MQGE aged spouse (third claimant)  
TJ = MQGE aged spouse (fourth claimant)  
TK = MQGE aged spouse (fifth claimant)  
TL = MQGE aged widow(er) (second claimant)  
TM = MQGE aged widow(er) (third claimant)  
TN = MQGE aged widow(er) (fourth claimant)  
TP = MQGE aged widow(er) (fifth claimant)  
TQ = MQGE parent (female)  
TR = MQGE young widow(er) (second claimant)  
TS = MQGE young widow(er) (third claimant)  
TT = MQGE young widow(er) (fourth claimant)  
TU = MQGE young widow(er) (fifth claimant)  
TV = MQGE disabled widow(er) fifth claimant  
TW = MQGE disabled widow(er) first claimant  
TX = MQGE disabled widow(er) second claimant  
TY = MQGE disabled widow(er) third claimant  
TZ = MQGE disabled widow(er) fourth claimant  
T2-T9 = Disabled child (second to ninth  
claimant)  
W = Disabled widow, age 50 or over (1st  
claimant)  
W1 = Disabled widower, age 50 or over (1st  
claimant)  
W2 = Disabled widow (2nd claimant)  
W3 = Disabled widower (2nd claimant)  
W4 = Disabled widow (3rd claimant)  
W5 = Disabled widower (3rd claimant)  
W6 = Disabled surviving divorced wife (1st

claimant)  
W7 = Disabled surviving divorced wife (2nd claimant)  
W8 = Disabled surviving divorced wife (3rd claimant)  
W9 = Disabled widow (4th claimant)  
WB = Disabled widower (4th claimant)  
WC = Disabled surviving divorced wife (4th claimant)  
WF = Disabled widow (5th claimant)  
WG = Disabled widower (5th claimant)  
WJ = Disabled surviving divorced wife (5th claimant)  
WR = Disabled surviving divorced husband (1st claimant)  
WT = Disabled surviving divorced husband (2nd claimant)

Railroad Retirement Board:

NOTE:  
Employee: a Medicare beneficiary who is still working or a worker who died before retirement  
Annuitant: a person who retired under the railroad retirement act on or after 03/01/37  
Pensioner: a person who retired prior to 03/01/37 and was included in the railroad retirement act

1 BENE\_IDENT\_TB Beneficiary Identification Code (BIC) Table  
-----

10 = Retirement - employee or annuitant  
80 = RR pensioner (age or disability)  
14 = Spouse of RR employee or annuitant (husband or wife)  
84 = Spouse of RR pensioner  
43 = Child of RR employee  
13 = Child of RR annuitant  
17 = Disabled adult child of RR annuitant  
46 = Widow/widower of RR employee  
16 = Widow/widower of RR annuitant  
86 = Widow/widower of RR pensioner  
43 = Widow of employee with a child in her care  
13 = Widow of annuitant with a child in her care  
83 = Widow of pensioner with a child in her care  
45 = Parent of employee  
15 = Parent of annuitant  
85 = Parent of pensioner  
11 = Survivor joint annuitant (reduced benefits taken to insure benefits for surviving spouse)

1 BENE\_PRMRY\_PYR\_TB Beneficiary Primary Payer Table  
-----

A = Working aged bene/spouse with employer

group health plan (EGHP)

B = End stage renal disease (ESRD) beneficiary  
in the 18 month coordination period with  
an employer group health plan

C = Conditional payment by Medicare; future  
reimbursement expected

D = Automobile no-fault (eff. 4/97; Prior  
to 3/94, also included any liability  
insurance)

E = Workers' compensation

F = Public Health Service or other federal  
agency (other than Dept. of Veterans  
Affairs)

G = Working disabled bene (under age 65  
with LGHP)

H = Black Lung

I = Dept. of Veterans Affairs

J = Any liability insurance  
(eff. 3/94 - 3/97)

L = Any liability insurance (eff. 4/97)  
(eff. 12/90 for carrier claims and 10/93  
for FI claims; obsoleted for all claim  
types 7/1/96)

M = Override code: EGHP services involved  
(eff. 12/90 for carrier claims and 10/93  
for FI claims; obsoleted for all claim  
types 7/1/96)

N = Override code: non-EGHP services involved  
(eff. 12/90 for carrier claims and 10/93  
for FI claims; obsoleted for all claim  
types 7/1/96)

BLANK = Medicare is primary payer (not sure  
of effective date: in use 1/91, if  
not earlier)

T = MSP cost avoided - IEQ contractor  
(eff. 7/96 carrier claims only)

U = MSP cost avoided - HMO rate cell adjust-  
ment contractor (eff. 7/96 carrier claims  
only)

V = MSP cost avoided - litigation settlement  
contractor (eff. 7/96 carrier claims  
only)

X = MSP cost avoided override code (eff.  
12/90 for carrier claims and 10/93 for  
FI claims; obsoleted for all claim types  
7/1/96)

\*\*\*Prior to 12/90\*\*\*

Y = Other secondary payer investigation  
shows Medicare as primary payer

Z = Medicare is primary payer

Beneficiary Primary Payer Table

-----

NOTE: Values C, M, N, Y, Z and BLANK  
indicate Medicare is primary payer.  
(values Z and Y were used prior to  
12/90. BLANK was suppose to be  
effective after 12/90, but may have  
been used prior to that date.)

M1A = Office visits - new  
M1B = Office visits - established  
M2A = Hospital visit - initial  
M2B = Hospital visit - subsequent  
M2C = Hospital visit - critical care  
M3 = Emergency room visit  
M4A = Home visit  
M4B = Nursing home visit  
M5A = Specialist - pathology  
M5B = Specialist - psychiatry  
M5C = Specialist - opthamology  
M5D = Specialist - other  
M6 = Consultations  
P0 = Anesthesia  
P1A = Major procedure - breast  
P1B = Major procedure - colectomy  
P1C = Major procedure - cholecystectomy  
P1D = Major procedure - turp  
P1E = Major procedure - hysterctomy  
P1F = Major procedure - explor/decompr/excisdisc  
P1G = Major procedure - Other  
P2A = Major procedure, cardiovascular-CABG  
P2B = Major procedure, cardiovascular-Aneurysm repair  
P2C = Major Procedure, cardiovascular-Thromboendarterectomy  
P2D = Major procedure, cardiovascularr-Coronary angioplasty (PTCA)  
P2E = Major procedure, cardiovascular-Pacemaker insertion  
P2F = Major procedure, cardiovascular-Other  
P3A = Major procedure, orthopedic - Hip fracture repair  
P3B = Major procedure, orthopedic - Hip replacement  
P3C = Major procedure, orthopedic - Knee replacement  
P3D = Major procedure, orthopedic - other  
P4A = Eye procedure - corneal transplant  
P4B = Eye procedure - cataract removal/lens insertion  
P4C = Eye procedure - retinal detachment  
P4D = Eye procedure - treatment  
P4E = Eye procedure - other  
P5A = Ambulatory procedures - skin  
P5B = Ambulatory procedures - musculoskeletal  
P5C = Ambulatory procedures - inguinal hernia repair  
P5D = Ambulatory procedures - lithotripsy  
P5E = Ambulatory procedures - other  
P6A = Minor procedures - skin  
P6B = Minor procedures - musculoskeletal  
P6C = Minor procedures - other (Medicare fee schedule)

1 BETOS\_TB  
-----

I1A = Standard imaging - chest  
I1B = Standard imaging - musculoskeletal  
I1C = Standard imaging - breast  
I1D = Standard imaging - contrast gastrointestinal  
I1E = Standard imaging - nuclear medicine  
I1F = Standard imaging - other  
I2A = Advanced imaging - CAT: head  
I2B = Advanced imaging - CAT: other  
I2C = Advanced imaging - MRI: brain  
I2D = Advanced imaging - MRI: other  
I3A = Echography - eye  
I3B = Echography - abdomen/pelvis  
I3C = Echography - heart  
I3D = Echography - carotid arteries  
I3E = Echography - prostate, transrectal  
I3F = Echography - other  
I4A = Imaging/procedure - heart including cardiac  
catheter  
I4B = Imaging/procedure - other  
T1A = Lab tests - routine venipuncture (non Medicare  
fee schedule)  
T1B = Lab tests - automated general profiles  
T1C = Lab tests - urinalysis  
T1D = Lab tests - blood counts  
T1E = Lab tests - glucose  
T1F = Lab tests - bacterial cultures  
T1G = Lab tests - other (Medicare fee schedule)  
T1H = Lab tests - other (non-Medicare fee schedule)  
T2A = Other tests - electrocardiograms  
T2B = Other tests - cardiovascular stress tests  
T2C = Other tests - EKG monitoring  
T2D = Other tests - other  
D1A = Medical/surgical supplies  
D1B = Hospital beds  
D1C = Oxygen and supplies  
D1D = Wheelchairs  
D1E = Other DME  
D1F = Orthotic devices  
O1A = Ambulance  
O1B = Chiropractic  
O1C = Enteral and parenteral  
O1D = Chemotherapy

01E = Other drugs  
01F = Vision, hearing and speech services  
01G = Influenza immunization  
Y1 = Other - Medicare fee schedule  
Y2 = Other - non-Medicare fee schedule  
Z1 = Local codes  
Z2 = Undefined codes

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CARR\_CLM\_PMT\_DNL\_TB

Carrier Claim Payment Denial Table

0 = Denied  
1 = Physician/supplier  
2 = Beneficiary  
3 = Both physician/supplier and beneficiary  
4 = Hospital (hospital based physicians)  
5 = Both hospital and beneficiary  
6 = Group practice prepayment plan  
7 = Other entries (e.g. Employer, union)  
8 = Federally funded  
9 = PA service  
A = Beneficiary under limitation of liability  
B = Physician/supplier under limitation of liability  
D = Denied due to demonstration involvement (eff. 5/97)  
E = MSP cost avoided IRS/SSA/HCFA Data Match (eff. 7/3/00)  
F = MSP cost avoided HMO Rate Cell (eff. 7/3/00)  
G = MSP cost avoided Litigation Settlement (eff. 7/3/00)  
H = MSP cost avoided Employer Voluntary Reporting (eff. 7/3/00)  
J = MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)  
K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)  
P = Physician ownership denial (eff 3/92)  
Q = MSP cost avoided - (Contractor #88888) voluntary agreement (eff. 1/98)  
T = MSP cost avoided - IEQ contractor (eff. 7/96) (obsolete 6/30/00)  
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96) (obsolete 6/30/00)  
V = MSP cost avoided - litigation settlement (eff. 7/96) (obsolete 6/30/00)  
X = MSP cost avoided - generic  
Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)

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CARR\_LINE\_PRVDR\_TYPE\_TB

Carrier Line Provider Type Table

For Physician/Supplier (RIC O) Claims:

- 0 = Clinics, groups, associations, partnerships, or other entities
- 1 = Physicians or suppliers reporting as solo practitioners
- 2 = Suppliers (other than sole proprietorship)
- 3 = Institutional provider
- 4 = Independent laboratories
- 5 = Clinics (multiple specialties)
- 6 = Groups (single specialty)
- 7 = Other entities

For DMERC (RIC M) Claims - PRIOR TO VERSION H:

- 0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.
- 1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.
- 2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.
- 3 = Suppliers (other than sole proprietorship) for whom EI numbers are used in coding the ID field.
- 4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.
- 5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.
- 6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
- 7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
- 8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

1 CARR\_LINE\_RDCD\_PHYSN\_ASTNT\_TB

Carrier Line Part B Reduced Physician Assistant Table

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- BLANK = Adjustment situation (where CLM\_DISP\_CD equal 3)
- 0 = N/A
  - 1 = 65%
    - A) Physician assistants assisting in surgery
    - B) Nurse midwives
  - 2 = 75%
    - A) Physician assistants performing services in a hospital (other than

- assisting surgery)
  - B) Nurse practitioners and clinical nurse specialists performing services in rural areas
  - C) Clinical social worker services
- 3 = 85%
- A) Physician assistant services for other than assisting surgery
  - B) Nurse practitioners services

00510 = Alabama BS (eff. 1983)  
00511 = Georgia - Alabama BS (eff. 1998)  
00512 = Mississippi - Alabama BS (eff. 2000)  
00520 = Arkansas BS (eff. 1983)  
00521 = New Mexico - Arkansas BS (eff. 1998)  
00522 = Oklahoma - Arkansas BS (eff. 1998)  
00523 = Missouri - Arkansas BS (eff. 1999)  
00528 = Louisiana - Arkansas BS (eff. 1984)  
00542 = California BS (eff. 1983; term. 1996)  
00550 = Colorado BS (eff. 1983; term. 1994)  
00570 = Delaware - Pennsylvania BS (eff. 1983; term. 1997)  
00580 = District of Columbia - Pennsylvania BS (eff. 1983; term. 1997)  
00590 = Florida BS (eff. 1983)  
00591 = Connecticut - Florida BS (eff. 2000)  
00621 = Illinois BS - HCSC (eff. 1983; term. 1998)  
00623 = Michigan - Illinois Blue Shield (eff. 1995) (term. 1998)  
00630 = Indiana - Administar (eff. 1983)  
00635 = DMERC-B (Administar Federal, Inc.) (eff. 1993)  
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)  
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)  
00650 = Kansas BS (eff. 1983)  
00655 = Nebraska - Kansas BS (eff. 1988)  
00660 = Kentucky - Administar (eff. 1983)  
00690 = Maryland BS (eff. 1983; term. 1994)  
00700 = Massachusetts BS (eff. 1983; term. 1997)  
00710 = Michigan BS (eff. 1983; term. 1994)  
00720 = Minnesota BS (eff. 1983; term. 1995)  
00740 = Missouri - BS Kansas City (eff. 1983)  
00751 = Montana BS (eff. 1983)  
00770 = New Hampshire/Vermont Physician Services (eff. 1983; term. 1984)  
00780 = New Hampshire/Vermont - Massachusetts BS (eff. 1985; term. 1997)  
00801 = New York - Western BS (eff. 1983)  
00803 = New York - Empire BS (eff. 1983)  
00805 = New Jersey - Empire BS (eff. 3/99)  
00811 = DMERC (A) - Western New York BS (eff. 2000)  
00820 = North Dakota - North Dakota BS (eff. 1983)  
00824 = Colorado - North Dakota BS (eff. 1995)  
00825 = Wyoming - North Dakota BS (eff. 1990)

00826	= Iowa - North Dakota BS (eff. 1999)
00831	= Alaska - North Dakota BS (eff. 1998)
00832	= Arizona - North Dakota BS (eff. 1998)
00833	= Hawaii - North Dakota BS (eff. 1998)
00834	= Nevada - North Dakota BS (eff. 1998)
00835	= Oregon - North Dakota BS (eff. 1998)
00836	= Washington - North Dakota BS (eff. 1998)
00860	= New Jersey - Pennsylvania BS (eff. 1988; term. 1999)
00865	= Pennsylvania BS (eff. 1983)
00870	= Rhode Island BS (eff. 1983)
00880	= South Carolina BS (eff. 1983)
00882	= RRB - South Carolina PGBA (eff. 2000)
	Carrier Number Table -----
00885	= DMERC C - Palmetto (eff. 1993)
00900	= Texas BS (eff. 1983)
00901	= Maryland - Texas BS (eff. 1995)
00902	= Delaware - Texas BS (eff. 1998)
00903	= District of Columbia - Texas BS (eff. 1998)
00904	= Virginia - Texas BS (eff. 2000)
00910	= Utah BS (eff. 1983)
00951	= Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952	= Illinois - Wisconsin Phy Svc (eff. 1999)
00953	= Michigan - Wisconsin Phy Svc (eff. 1999)
00954	= Minnesota - Wisconsin Phy Svc (eff. 2000)
00973	= Triple-S, Inc. - Puerto Rico (eff. 1983)
00974	= Triple-S, Inc. - Virgin Islands
01020	= Alaska - AETNA (eff. 1983; term. 1997)
01030	= Arizona - AETNA (eff. 1983; term. 1997)
01040	= Georgia - AETNA (eff. 1988; term. 1997)
01120	= Hawaii - AETNA (eff. 1983; term. 1997)
01290	= Nevada - AETNA (eff. 1983; term. 1997)
01360	= New Mexico - AETNA (eff. 1986; term. 1997)
01370	= Oklahoma - AETNA (eff. 1983; term. 1997)
01380	= Oregon - AETNA (eff. 1983; term. 1997)
01390	= Washington - AETNA (eff. 1994; term. 1997)
02050	= California - TOLIC (eff. 1983) (term. 2000)
03070	= Connecticut General Life Insurance Co. (eff. 1983; term. 1985)
05130	= Idaho - Connecticut General (eff. 1983)
05320	= New Mexico - Equitable Insurance (eff. 1983; term. 1985)
05440	= Tennessee - Connecticut General (eff. 1983)
05530	= Wyoming - Equitable Insurance (eff. 1983) (term. 1989)
05535	= North Carolina - Connecticut General (eff. 1988)
05655	= DMERC-D - Connecticut General (eff. 1993)
10071	= Railroad Board Travelers (eff. 1983) (term. 2000)
10230	= Connecticut - Metra Health (eff. 1986) (term. 2000)
10240	= Minnesota - Metra Health (eff. 1983) (term. 2000)
10250	= Mississippi - Metra Health (eff. 1983)

(term. 2000)  
10490 = Virginia - Metra Health (eff. 1983)  
(term. 2000)  
10555 = Travelers Insurance Co. (eff. 1993)  
(term. 2000)  
11260 = Missouri - General American Life  
(eff. 1983; term. 1998)  
14330 = New York - GHI (eff. 1983)  
16360 = Ohio - Nationwide Insurance Co.  
16510 = West Virginia - Nationwide Insurance Co.  
21200 = Maine - BS of Massachusetts  
31140 = California - National Heritage Ins.  
31142 = Maine - National Heritage Ins.  
31143 = Massachusetts - National Heritage Ins.  
31144 = New Hampshire - National Heritage Ins.  
31145 = Vermont - National Heritage Ins.

1 CARR\_NUM\_TB  
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Carrier Number Table  
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31146 = So. California - NHIC (eff. 2000)

1 CLM\_BILL\_TYPE\_TB  
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Claim Bill Type Table  
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11 = Hospital-inpatient (including Part A)  
12 = Hospital-inpatient or home health visits (Part B only)  
13 = Hospital-outpatient (HHA-A also) (under OPPS 13X  
must be used for ASC claims submitted for OPPS  
payment -- eff. 7/00)  
14 = Hospital-other (Part B)  
15 = Hospital-intermediate care - level I  
16 = Hospital-intermediate care - level II  
17 = Hospital-intermediate care - level III  
18 = Hospital-swing beds  
19 = Hospital-reserved for national assignment  
21 = SNF-inpatient (including Part A)  
22 = SNF-inpatient or home health visits (Part B only)  
23 = SNF-outpatient (HHA-A also)  
24 = SNF-other (Part B)  
25 = SNF-intermediate care - level I  
26 = SNF-intermediate care - level II  
27 = SNF-intermediate care - level III  
28 = SNF-swing beds  
29 = SNF-reserved for national assignment  
31 = HHA-inpatient (including Part A)  
32 = HHA-inpatient or home health visits (Part B only)  
33 = HHA-outpatient (HHA-A also)  
34 = HHA-other (Part B)  
35 = HHA-intermediate care - level I  
36 = HHA-intermediate care - level II  
37 = HHA-intermediate care - level III  
38 = HHA-swing beds  
39 = HHA-reserved for national assignment  
41 = Religious Nonmedical Health Care Institution (RNHCI)  
hospital-inpatient (including Part A) (all references  
to Christian Science (CS) is obsolete eff. 8/00 and  
replaced with RNHCI)  
42 = RNHCI hospital-inpatient or home health visits (Part B only)

- 43 = RNHCI hospital-outpatient (HHA-A also)
- 44 = RNHCI hospital-other (Part B)
- 45 = RNHCI hospital-intermediate care - level I
- 46 = RNHCI hospital-intermediate care - level II
- 47 = RNHCI hospital-intermediate care - level III
- 48 = RNHCI hospital-swing beds
- 49 = RNHCI hospital-reserved for national assignment
- 51 = CS extended care-inpatient (including Part A) OBSOLETE  
eff. 7/00 - implementation of Religious Nonmedical  
Health Care Institutions (RNHCI)
- 52 = RNHCI extended care-inpatient or home health visits  
(Part B only) (eff. 7/00); prior to 7/00 Christian Science (CS)
- 53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);  
prior to 7/00 referenced CS
- 54 = RNHCI extended care-other (Part B) (eff. 7/00); prior  
to 7/00 referenced CS
- 55 = RNHCI extended care-intermediate care - level I (eff. 7/00)  
prior to 7/00 referenced CS
- 56 = RNHCI extended care-intermediate care - level II (eff. 7/00)  
prior to 7/00 referenced CS
- 57 = RNHCI extended care-intermediate care - level III (eff. 7/00)  
prior to 7/00 referenced CS
- 58 = RNHCI extended care-swing beds (eff. 7/00)
- 59 = RNHCI extended care-reserved for national assignment  
(eff. 7/00); prior to 7/00 referenced CS
- 61 = Intermediate care-inpatient (including Part A)
- 62 = Intermediate care-inpatient or home health visits (Part B only)
- 63 = Intermediate care-outpatient (HHA-A also)
- 64 = Intermediate care-other (Part B)
- 65 = Intermediate care-intermediate care - level I
- 66 = Intermediate care-intermediate care - level II
- 67 = Intermediate care-intermediate care - level III
- 68 = Intermediate care-swing beds
- 69 = Intermediate care-reserved for national assignment
- 71 = Clinic-rural health
- 72 = Clinic-hospital based or independent renal dialysis facility
- 73 = Clinic-independent provider based FQHC (eff 10/91)
- 74 = Clinic-ORF only (eff 4/97);  
ORF and CMHC (10/91 - 3/97)
- 75 = Clinic-CORF
- 76 = Clinic-CMHC (eff 4/97)
- 77 = Clinic-reserved for national assignment
- 78 = Clinic-reserved for national assignment
- 79 = Clinic-other
- 81 = Special facility or ASC surgery-hospice (non-hospital based)
- 82 = Special facility or ASC surgery-hospice (hospital based)
- 83 = Special facility or ASC surgery-ambulatory surgical center  
(Discontinued for Hospitals Subject to Outpatient PPS;  
hospitals must use 13X for ASC claims submitted for OPPS  
payment -- eff. 7/00)
- 84 = Special facility or ASC surgery-freestanding birthing center
- 85 = Special facility or ASC surgery-rural primary care hospital (eff
- 86 = Special facility or ASC surgery-reserved for national use
- 87 = Special facility or ASC surgery-reserved for national use

88 = Special facility or ASC surgery-reserved for national use  
89 = Special facility or ASC surgery-other  
91 = Reserved-inpatient (including Part A)  
92 = Reserved-inpatient or home health visits (Part B only)  
93 = Reserved-outpatient (HHA-A also)  
94 = Reserved-other (Part B)  
95 = Reserved-intermediate care - level I  
96 = Reserved-intermediate care - level II  
97 = Reserved-intermediate care - level III  
98 = Reserved-swing beds  
99 = Reserved-reserved for national assignment

1 CLM\_DISP\_TB Claim Disposition Table  
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01 = Debit accepted  
02 = Debit accepted (automatic adjustment)  
applicable through 4/4/93  
03 = Cancel accepted  
61 = \*Conversion code: debit accepted  
62 = \*Conversion code: debit accepted  
(automatic adjustment)  
63 = \*Conversion code: cancel accepted

\*Used only during conversion period:  
1/1/91 - 2/21/91

1 CLM\_FAC\_TYPE\_TB Claim Facility Type Table  
-----

1 = Hospital  
2 = Skilled nursing facility (SNF)  
3 = Home health agency (HHA)  
4 = Religious Nonmedical (Hospital)  
(eff. 8/1/00); prior to 8/00 referenced Christian  
Science (CS)  
5 = Religious Nonmedical (Extended Care)  
(eff. 8/1/00); prior to 8/00 referenced CS  
6 = Intermediate care  
7 = Clinic or hospital-based renal dialysis facility  
8 = Special facility or ASC surgery  
9 = Reserved

1 CLM\_FREQ\_TB Claim Frequency Table  
-----

0 = Non-payment/zero claims  
1 = Admit thru discharge claim  
2 = Interim - first claim  
3 = Interim - continuing claim  
4 = Interim - last claim  
5 = Late charge(s) only claim  
6 = Adjustment of prior claim  
7 = Replacement of prior claim;  
eff 10/93, provider debit

8 = Void/cancel prior claim.  
    eff 10/93, provider cancel  
9 = Final claim -- used in an HH PPS  
    episode to indicate the claim  
    should be processed like debit/  
    credit adjustment to RAP (initial  
    claim) (eff. 10/00)  
A = Admission notice - used when hospice  
    is submitting the HCFA-1450 as an  
    admission notice - hospice NOE only  
B = Hospice termination/revocation notice  
    - hospice NOE only (eff 9/93)  
C = Hospice change of provider notice  
    - hospice NOE only (eff 9/93)  
D = Hospice election void/cancel  
    - hospice NOE only (eff 9/93)  
E = Hospice change of ownership  
    - hospice NOE only (eff 1/97)  
F = Beneficiary initiated adjustment  
    (eff 10/93)  
G = CWF generated adjustment (eff 10/93)  
H = HCFA generated adjustment (eff 10/93)  
I = Misc adjustment claim (other than PRO  
    or provider) - used to identify a  
    debit adjustment initiated by HCFA or  
    an intermediary - eff 10/93, used to  
    identify intermediary initiated  
    adjustment only  
J = Other adjustment request (eff 10/93)  
K = OIG initiated adjustment (eff 10/93)  
M = MSP adjustment (eff 10/93)  
P = Adjustment required by peer review  
    organization (PRO)  
X = Special adjustment processing - used  
    for QA editing (eff 8/92)  
Z = Hospital Encounter Data alternate sub-  
    mission (TOB '11Z') used for MCO enrollee  
    hospital discharges 7/1/97-12/31/98; not  
    stored in NCH. Exception: Problem in  
    startup months may have resulted in this  
    abbreviated UB-92 being erroneously  
    stored in NCH.

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CLM\_HHA\_RFRL\_TB

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Claim Home Health Referral Table

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1 = Physician referral - The patient was  
    admitted upon the recommendation of  
    a personal physician.  
2 = Clinic referral - The patient was  
    admitted upon the recommendation of  
    this facility's clinic physician.  
3 = HMO referral - The patient was admitted  
    upon the recommendation of an health  
    maintenance organization (HMO)  
    physician.  
4 = Transfer from hospital - The patient

was admitted as an inpatient transfer from an acute care facility.

5 = Transfer from a skilled nursing facility (SNF) - The patient was admitted as an inpatient transfer from a SNF.

6 = Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.

7 = Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician.

8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.

9 = Information not available - The means by which the patient was admitted is not known.

A = Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.

B = Transfer from another HHA - Beneficiaries are permitted to transfer from one HHA to another unrelated HHA under HH PPS. (eff. 10/00)

C = Readmission to same HHA - If a beneficiary is discharged from an HHA and then re-admitted within the original 60-day episode, the original episode must be closed early and a new one created. NOTE: the use of this code will permit the agency to send a new RAP allowing all claims to be accepted by Medicare. (eff. 10/00)

\*\*\*\*\* SNF PPS HIPPS \*\*\*\*\*

\*\*\*\*\*1st 3 positions (RUGS-III group)\*\*\*\*\*

AAA = Default: No assessment

BA1,BA2,BB1,BB2 = Behavior only problems (e.g., physical/verbal abuse)

CA1,CA2,CB1,CB2 = Clinically-complex conditions (e.g., chemo, dialysis)

CC1,CC2

IA1,IA2,IB1,IB2 = Impaired cognition (e.g., im-paired cognition (e.g., short-term memory)

PA1,PA2,PB1,PB2 = Reduced physical functions  
PC1,PC2,PD1,PD2  
PE1,PE2

RHA,RHB,RHC,RLA = Low/medium/high rehabilitation  
RLB,RMA,RMB,RMC

RUA,RUB,RUC,RVA = Very high/ultra high rehabilita-  
RVB,RVC tion: highest level

SE1,SE2,SE3 = Extensive services; e.g.; IV feed  
trach care

SSA,SSB,SSC = Special care; e.g.; coma, burns

\*\*\*\*\*Positions 4 & 5 represent HIPPS modifier/\*\*\*\*\*  
\*\*\*\*\* assessment type indicator \*\*\*\*\*

00 = No assessment completed  
01 = Medicare 5-day full assessment/not an initial  
admission assessment  
02 = Medicare 30-day full assessment  
03 = Medicare 60-day full assessment  
04 = Medicare 90-day full assessment  
05 = Medicare Readmission/Return required assessment  
(eff. 10/2000)  
07 = Medicare 14-day full or comprehensive assessment/  
not an initial admission assessment  
08 = Off-cycle Other Medicare Required Assessment (OMRA)  
11 = Admission assessment AND Medicare 5-day (or readmission/  
return) assessment  
17 = Medicare 14-day required assessment AND initial  
admission assessment (eff. 10/2000)  
18 = OMRA replacing Medicare 5-day required assessment  
(eff. 10/2000)  
28 = OMRA replacing Medicare 30-day required assessment  
(eff. 10/2000)  
30 = Off-cycle significant change assessment (outside  
assessment window) (eff. 10/2000)  
31 = Significant change assessment replaces Medicare  
5-day assessment (eff. 10/2000)  
32 = Significant change assessment replaces Medicare  
30-day assessment

Claim SNF & HHA Health Insurance	PPS Table
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33 = Significant change assessment replaces Medicare  
6--day assessment  
34 = Significant change assessment replaces Medicare  
90-day assessment  
35 = Significant change assessment replaces a Medicare  
readmission/return assessment  
37 = Significant change assessment replaces Medicare  
14-day assessment  
38 = OMRA replacing Medicare 60-day required  
assessment  
40 = Off-cycle significant correction assessment of a

prior assessment (outside assessment window)  
(eff. 10/2000)  
41 = Significant correction of prior full assessment  
replaces a Medicare 5-day assessment  
42 = Significant correction of prior full assessment  
replaces a Medicare 30-day assessment  
43 = Significant correction of prior full assessment  
replaces a Medicare 60-day assessment  
44 = Significant correction of prior full assessment  
replaces a Medicare 90-day assessment  
45 = Significant correction of a prior assessment  
replaces a readmission/return assessment  
(eff. 10/2000)  
47 = Significant correction of prior full assessment  
replaces a Medicare 14-day required assessment  
48 = OMRA replacing Medicare 90-day required assessment  
54 = Quarterly review assessment - Medicare 90-day  
full assessment  
78 = OMRA replacing a Medicare 14-day assessment  
(eff. 10/2000)

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\*\*\*\*\*

\*\*\*\*\*Claim Home Health PPS HIPPS Table\*\*\*\*\*  
\*\*\*\*\* KEY \*\*\*\*\*

Position 1 = 'H'  
Position 2 = Clinical (A, B, C, D)  
Position 3 = Functional (E, F, G, H, I)  
Position 4 = Service (J, K, K, M)  
Position 5 = identifies which elements of the code were  
computed or derived:  
1 = 2nd, 3rd, 4th positions computed  
2 = 2nd position derived  
3 = 3rd position derived  
4 = 4th position derived  
5 = 2nd & 3rd positions derived  
6 = 3rd & 4th positions derived  
7 = 2nd & 4th positions derived  
8 = 2nd, 3rd, 4th positions derived  
\*\*\*\*\*

\*\*HHRG = C0F0S0/Clinical = Min, Functional = Min, Service = Min\*\*  
HAEJ1  
HAEJ2  
HAEJ3

Claim SNF & HHA Health Insurance PPS Table  
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HAEJ4  
HAEJ5  
HAEJ6  
HAEJ7  
HAEJ8  
\*\*HHRG = C0F0S1/Clinical = Min, Functional = Min, Service = Low\*\*  
HAEK1  
HAEK2

HAEK3	
HAEK4	
HAEK5	
HAEK6	
HAEK7	
HAEK8	
**HHRG = C0F0S2/Clinical = Min, Functional = Min, Service = Mod**	
HAEL1	
HAEL2	
HAEL3	
HAEL4	
HAEL5	
HAEL6	
HAEL7	
HAEL8	
**HHRG = C0F0S3/Clinical = Min, Functional = Min, Service = High**	
HAEM1	
HAEM2	
HAEM3	
HAEM4	
HAEM5	
HAEM6	
HAEM7	
HAEM8	
**HHRG = C0F1S0/Clinical = Min, Functional = Low, Service = Min**	
HAFJ1	
HAFJ2	
HAFJ3	
HAFJ4	
HAFJ5	
HAFJ6	
HAFJ7	
HAFJ8	
**HHRG = C0F1S1/Clinical = Min, Functional = Low, Service = Low**	
HAFK1	
HAFK2	
HAFK3	
HAFK4	
HAFK5	
HAFK6	
HAFK7	
HAFK8	
**HHRG = C0F1S2/Clinical = Min, Functional = Low, Service = Mod**	
HAFL1	
HAFL2	
HAFL3	
HAFL4	
HAFL5	
HAFL6	
HAFL7	
Claim SNF & HHA Health Insurance PPS Table	
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HAFL8	
**HHRG = C0F1S3/Clinical = Min, Functional = Low, Service = High**	
HAFM1	
HAFM2	
HAFM3	

HAFM4	
HAFM5	
HAFM6	
HAFM7	
HAFM8	
**HHRG = C0F2S0/Clinical = Min, Functional = Mod, Service = Min**	
HAGJ1	
HAGJ2	
HAGJ3	
HAGJ4	
HAGJ5	
HAGJ6	
HAGJ7	
HAGJ8	
**HHRG = C0F2S1/Clinical = Min, Functional = Mod, Service = Low**	
HAGK1	
HAGK2	
HAGK3	
HAGK4	
HAGK5	
HAGK6	
HAGK7	
HAGK8	
**HHRG = C0F2S2/Clinical = Min, Functional = Mod, Service = Mod**	
HAGL1	
HAGL2	
HAGL3	
HAGL4	
HAGL5	
HAGL6	
HAGL7	
HAGL8	
**HHRG = C0F2S3/Clinical = Min, Functional = Mod, Service = High**	
HAGM1	
HAGM2	
HAGM3	
HAGM4	
HAGM5	
HAGM6	
HAGM7	
HAGM8	
**HHRG = C0F3S0/Clinical = Min, Functional = High, Service = Min**	
HAHJ1	
HAHJ2	
HAHJ3	
HAHJ4	
HAHJ5	
HAHJ6	
HAHJ7	
HAHJ8	
**HHRG = C0F3S1/Clinical = Min, Functional = High, Service = Low**	
HAHK1	
HAHK2	
-----	
HAHK3	
HAHK4	

HAHK5  
HAHK6  
HAHK7  
HAHK8  
\*\*HHRG = C0F3S2/Clinical = Min, Functional = High, Service = Mod\*\*  
HAHL1  
HAHL2  
HAHL3  
HAHL4  
HAHL5  
HAHL6  
HAHL7  
HAHL8  
\*\*HHRG = C0F3S3/Clinical = Min, Functional = High, Service = High\*\*  
HAHM1  
HAHM2  
HAHM3  
HAHM4  
HAHM5  
HAHM6  
HAHM7  
HAHM8  
\*\*HHRG = C0F4S0/Clinical = Min, Functional = Max, Service = Min\*\*  
HAIJ1  
HAIJ2  
HAIJ3  
HAIJ4  
HAIJ5  
HAIJ6  
HAIJ7  
HAIJ8  
\*\*HHRG = C0F4S1/Clinical = Min, Functional = Max, Service = Low\*\*  
HAIK1  
HAIK2  
HAIK3  
HAIK4  
HAIK5  
HAIK6  
HAIK7  
HAIK8  
\*\*HHRG = C0F4S2/Clinical = Min, Functional = Max, Service = Mod\*\*  
HAIL1  
HAIL2  
HAIL3  
HAIL4  
HAIL5  
HAIL6  
HAIL7  
HAIL8  
\*\*HHRG = C0F4S3/Clinical = Min, Functional = Max, Service = High\*\*  
HAIM1  
HAIM2  
HAIM3  
HAIM4  
HAIM5  
HAIM6

HAIM7  
HAIM8  
\*\*HHRG = C1F0S0/Clinical = Low, Functional = Min, Service = Min\*\*  
HBEJ1  
HBEJ2  
HBEJ3  
HBEJ4  
HBEJ5  
HBEJ6  
HBEJ7  
HBEJ8  
\*\*HHRG = C1F0S1/Clinical = Low, Functional = Min, Service = Low\*\*  
HBEK1  
HBEK2  
HBEK3  
HBEK4  
HBEK5  
HBEK6  
HBEK7  
HBEK8  
\*\*HHRG = C1F0S2/Clinical = Low, Functional = Min, Service = Mod\*\*  
HBEL1  
HBEL2  
HBEL3  
HBEL4  
HBEL5  
HBEL6  
HBEL7  
HBEL8  
\*\*HHRG = C1F0S3/Clinical = Low, Functional = Min, Service = High\*\*  
HBEM1  
HBEM2  
HBEM3  
HBEM4  
HBEM5  
HBEM6  
HBEM7  
HBEM8  
\*\*HHRG = C1F1S0/Clinical = Low, Functional = Low, Service = Min\*\*  
HBFJ1  
HBFJ2  
HBFJ3  
HBFJ4  
HBFJ5  
HBFJ6  
HBFJ7  
HBFJ8  
\*\*HHRG = C1F1S1/Clinical = Low, Functional = Low, Service = Low\*\*  
HBFK1  
HBFK2  
HBFK3  
HBFK4  
HBFK5  
HBFK6  
HBFK7  
HBFK8  
\*\*HHRG = C1F1S2/Clinical = Low, Functional = Low, Service = Mod\*\*

HBFL1	Claim SNF & HHA Health Insurance	PPS Table
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HBFL2		
HBFL3		
HBFL4		
HBFL5		
HBFL6		
HBFL7		
HBFL8		
**HHRG = C1F1S3/Clinical = Low, Functional = Low, Service = High**		
HBFM1		
HBFM2		
HBFM3		
HBFM4		
HBFM5		
HBFM6		
HBFM7		
HBFM8		
**HHRG = C1F2S0/Clinical = Low, Functional = Mod, Service = Min**		
HBGJ1		
HBGJ2		
HBGJ3		
HBGJ4		
HBGJ5		
HBGJ6		
HBGJ7		
HBGJ8		
**HHRG = C1F2S1/Clinical = Low, Functional = Mod, Service = Low**		
HBGK1		
HBGK2		
HBGK3		
HBGK4		
HBGK5		
HBGK6		
HBGK7		
HBGK8		
**HHRG = C1F2S2/Clinical = Low, Functional = Mod, Service = Mod**		
HBGL1		
HBGL2		
HBGL3		
HBGL4		
HBGL5		
HBGL6		
HBGL7		
HBGL8		
**HHRG = C1F2S3/Clinical = Low, Functional = Mod, Service = High**		
HBGM1		
HBGM2		
HBGM3		
HBGM4		
HBGM5		
HBGM6		
HBGM7		
HBGM8		
**HHRG = C1F3S0/Clinical = Low, Functional = High, Service = Min**		
HBHJ1		

HBHJ2	Claim SNF & HHA Health Insurance	PPS Table
HBHJ3		
HBHJ4		
HBHJ5		
HBHJ6		
HBHJ7		
HBHJ8		
**HHRG = C1F3S1/Clinical = Low, Functional = High, Service = Low**		
HBHK1		
HBHK2		
HBHK3		
HBHK4		
HBHK5		
HBHK6		
HBHK7		
HBHK8		
**HHRG = C1F3S2/Clinical = Low, Functional = High, Service = Mod**		
HBHL1		
HBHL2		
HBHL3		
HBHL4		
HBHL5		
HBHL6		
HBHL7		
HBHL8		
**HHRG = C1F3S3/Clinical = Low, Functional = High, Service = High**		
HBHM1		
HBHM2		
HBHM3		
HBHM4		
HBHM5		
HBHM6		
HBHM7		
HBHM8		
**HHRG = C1F4S0/Clinical = Low, Functional = Max, Service = Min**		
HBIJ1		
HBIJ2		
HBIJ3		
HBIJ4		
HBIJ5		
HBIJ6		
HBIJ7		
HBIJ8		
**HHRG = C1F4S1/Clinical = Low, Functional = Max, Service = Low**		
HBIK1		
HBIK2		
HBIK3		
HBIK4		
HBIK5		
HBIK6		
HBIK7		
HBIK8		
**HHRG = C1F4S2/Clinical = Low, Functional = Max, Service = Mod**		
HBIL1		
HBIL2		

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HBIL3  
HBIL4  
HBIL5  
HBIL6  
HBIL7  
HBIL8  
\*\*HHRG = C1F4S3/Clinical = Low, Functional = Max, Service = High\*\*  
Claim SNF & HHA Health Insurance PPS Table  
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HBIM1  
HBIM2  
HBIM3  
HBIM4  
HBIM5  
HBIM6  
HBIM7  
HBIM8  
\*\*HHRG = C2F0S0/Clinical = Mod, Functional = Min, Service = Min\*\*  
HCEJ1  
HCEJ2  
HCEJ3  
HCEJ4  
HCEJ5  
HCEJ6  
HCEJ7  
HCEJ8  
\*\*HHRG = C2F0S1/Clinical = Mod, Functional = Min, Service = Low\*\*  
HCEK1  
HCEK2  
HCEK3  
HCEK4  
HCEK5  
HCEK6  
HCEK7  
HCEK8  
\*\*HHRG = C2F0S2/Clinical = Mod, Functional = Min, Service = Mod\*\*  
HCEL1  
HCEL2  
HCEL3  
HCEL4  
HCEL5  
HCEL6  
HCEL7  
HCEL8  
\*\*HHRG = C2F0S3/Clinical = Mod, Functional = Min, Service = High\*\*  
HCEM1  
HCEM2  
HCEM3  
HCEM4  
HCEM5  
HCEM6  
HCEM7  
HCEM8  
\*\*HHRG = C2F1S0/Clinical = Mod, Functional = Low, Service = Min\*\*  
HCFJ1  
HCFJ2  
HCFJ3

HCFJ4		
HCFJ5		
HCFJ6		
HCFJ7		
HCFJ8		
**HHRG = C2F1S2/Clinical = Mod, Functional = Low, Service = Mod**		
HCFL1		
HCFL2		
HCFL3		
HCFL4		
Claim SNF & HHA Health Insurance PPS Table		
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HCFL5		
HCFL6		
HCFL7		
HCFL8		
**HHRG = C2F1S3/Clinical = Mod, Functional = Low, Service = High**		
HCFM1		
HCFM2		
HCFM3		
HCFM4		
HCFM5		
HCFM6		
HCFM7		
HCFM8		
**HHRG = C2F2S0/Clinical = Mod, Functional = Mod, Service = Min**		
HCGJ1		
HCGJ2		
HCGJ3		
HCGJ4		
HCGJ5		
HCGJ6		
HCGJ7		
HCGJ8		
**HHRG = C2F2S1/Clinical = Mod, Functional = Mod, Service = Low**		
HCGK1		
HCGK2		
HCGK3		
HCGK4		
HCGK5		
HCGK6		
HCGK7		
HCGK8		
**HHRG = C2F2S2/Clinical = Mod, Functional = Mod, Service = Mod**		
HCGL1		
HCGL2		
HCGL3		
HCGL4		
HCGL5		
HCGL6		
HCGL7		
HCGL8		
**HHRG = C2F2S3/Clinical = Mod, Functional = Mod, Service = High**		
HCGM1		
HCGM2		
HCGM3		
HCGM4		

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CLM\_HIPPS\_TB  
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HCGM5  
HCGM6  
HCGM7  
HCGM8  
\*\*HHRG = C2F3S0/Clinical = Mod, Functional = High, Service = Min\*\*  
HCHJ1  
HCHJ2  
HCHJ3  
HCHJ4  
HCHJ5  
HCHJ6  
HCHJ7  
HCHJ8  
  
Claim SNF & HHA Health Insurance                      PPS Table  
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\*\*HHRG = C2F3S1/Clinical = Mod, Functional = High, Service = Low\*\*  
HCHK1  
HCHK2  
HCHK3  
HCHK4  
HCHK5  
HCHK6  
HCHK7  
HCHK8  
\*\*HHRG = C2F3S2/Clinical = Mod, Functional = High, Service = Mod\*\*  
HCHL1  
HCHL2  
HCHL3  
HCHL4  
HCHL5  
HCHL6  
HCHL7  
HCHL8  
\*\*HHRG = C2F3S3/Clinical = Mod, Functional = High, Service = High\*\*  
HCHM1  
HCHM2  
HCHM3  
HCHM4  
HCHM5  
HCHM6  
HCHM7  
HCHM8  
\*\*HHRG = C2F4S0/Clinical = Mod, Functional = Max, Service = Min\*\*  
HCIJ1  
HCIJ2  
HCIJ3  
HCIJ4  
HCIJ5  
HCIJ6  
HCIJ7  
HCIJ8  
\*\*HHRG = C2F4S1/Clinical = Mod, Functional = Max, Service = Low\*\*  
HCIK1  
HCIK2  
HCIK3  
HCIK4  
HCIK5

HCIK6	
HCIK7	
HCIK8	
**HHRG = C2F4S2/Clinical = Mod, Functional = Max, Service = Mod**	
HCIL1	
HCIL2	
HCIL3	
HCIL4	
HCIL5	
HCIL6	
HCIL7	
HCIL8	
**HHRG = C2F4S3/Clinical = Mod, Functional = Max, Service = High**	
HCIM1	
HCIM2	
HCIM3	
	Claim SNF & HHA Health Insurance
	PPS Table
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HCIM4	
HCIM5	
HCIM6	
HCIM7	
HCIM8	
**HHRG = C3F0S0/Clinical = High, Functional = Min, Service = Min**	
HDEJ1	
HDEJ2	
HDEJ3	
HDEJ4	
HDEJ5	
HDEJ6	
HDEJ7	
HDEJ8	
**HHRG = C3F0S1/Clinical = High, Functional = Min, Service = Low**	
HDEK1	
HDEK2	
HDEK3	
HDEK4	
HDEK5	
HDEK6	
HDEK7	
HDEK8	
**HHRG = C3F0S2/Clinical = High, Functional = Min, Service = Mod**	
HDEL1	
HDEL2	
HDEL3	
HDEL4	
HDEL5	
HDEL6	
HDEL7	
HDEL8	
**HHRG = C3F0S3/Clinical = High, Functional = Min, Service = High**	
HDEM1	
HDEM2	
HDEM3	
HDEM4	
HDEM5	
HDEM6	

HDEM7	
HDEM8	
**HHRG = C3F1S0/Clinical = High, Functional = Low, Service = Min**	
HDFJ1	
HDFJ2	
HDFJ3	
HDFJ4	
HDFJ5	
HDFJ6	
HDFJ7	
HDFJ8	
**HHRG = C3F1S1/Clinical = High, Functional = Low, Service = Low**	
HDFK1	
HDFK2	
HDFK3	
HDFK4	
HDFK5	
HDFK6	
HDFK7	
Claim SNF & HHA Health Insurance PPS Table	
-----	
HDFK8	
**HHRG = C3F1S2/Clinical = High, Functional = Low, Service = Mod**	
HDFL1	
HDFL2	
HDFL3	
HDFL4	
HDFL5	
HDFL6	
HDFL7	
HDFL8	
**HHRG = C3F1S3/Clinical = High, Functional = Low, Service = High**	
HDFM1	
HDFM2	
HDFM3	
HDFM4	
HDFM5	
HDFM6	
HDFM7	
HDFM8	
**HHRG = C3F2S0/Clinical = High, Functional = Mod, Service = Min**	
HDGJ1	
HDGJ2	
HDGJ3	
HDGJ4	
HDGJ5	
HDGJ6	
HDGJ7	
HDGJ8	
**HHRG = C3F2S1/Clinical = High, Functional = Mod, Service = Low**	
HDGK1	
HDGK2	
HDGK3	
HDGK4	
HDGK5	
HDGK6	
HDGK7	

HDGK8	
**HHRG = C3F2S2/Clinical = High, Functional = Mod, Service = Mod**	
HDGL1	
HDGL2	
HDGL3	
HDGL4	
HDGL5	
HDGL6	
HDGL7	
HDGL8	
**HHRG = C3F2S3/Clinical = High, Functional = Mod, Service = High**	
HDGM1	
HDGM2	
HDGM3	
HDGM4	
HDGM5	
HDGM6	
HDGM7	
HDGM8	
**HHRG = C3F3S0/Clinical = High, Functional = High, Service = Min**	
HDHJ1	
HDHJ2	Claim SNF & HHA Health Insurance                      PPS Table
-----	
HDHJ3	
HDHJ4	
HDHJ5	
HDHJ6	
HDHJ7	
HDHJ8	
**HHRG = C3F3S1/Clinical = High, Functional = High, Service = Low**	
HDHK1	
HDHK2	
HDHK3	
HDHK4	
HDHK5	
HDHK6	
HDHK7	
HDHK8	
**HHRG = C3F3S2/Clinical = High, Functional = High, Service = Mod**	
HDHL1	
HDHL2	
HDHL3	
HDHL4	
HDHL5	
HDHL6	
HDHL7	
HDHL8	
**HHRG = C3F3S3/Clinical = High, Functional = High, Service = High**	
HDHM1	
HDHM2	
HDHM3	
HDHM4	
HDHM5	
HDHM6	
HDHM7	
HDHM8	

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CLM\_HIPPS\_TB

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\*\*\*\*HHRG = C3F4S0/Clinical = High, Functional = Max, Service = Min\*\*

HDIJ1

HDIJ2

HDIJ3

HDIJ4

HDIJ5

HDIJ6

HDIJ7

HDIJ8

\*\*\*\*HHRG = C3F4S1/Clinical = High, Functional = Max, Service = Low\*\*

HDIK1

HDIK2

HDIK3

HDIK4

HDIK5

HDIK6

HDIK7

HDIK8

\*\*\*\*HHRG = C3F4S2/Clinical = High, Functional = Max, Service = Mod\*\*

HDIL1

HDIL2

HDIL3

HDIL4

HDIL5

HDIL6

Claim SNF & HHA Health Insurance

PPS Table

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CLM\_IP\_ADMSN\_TYPE\_TB

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HDIL7

HDIL8

\*\*\*\*HHRG = C3F4S3/Clinical = High, Functional = Max, Service = High\*\*

HDIM1

HDIM2

HDIM3

HDIM4

HDIM5

HDIM6

HDIM7

HDIM8

Claim Inpatient Admission Type Table

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- 0 = Blank
- 1 = Emergency - The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
- 2 = Urgent - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
- 3 = Elective - The patient's condition

permitted adequate time to schedule the  
availability of suitable accommodations.  
4 = Newborn - Necessitates the use of  
special source of admission codes.

5 THRU 8 = Reserved.  
9 = Unknown - Information not available.

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CLM\_MDCR\_NPMT\_RSN\_TB

Claim Medicare Non-Payment Reason Table

A = Covered worker's compensation (Obsolete)  
B = Benefit exhausted  
C = Custodial care - noncovered care  
(includes all 'beneficiary at fault'  
waiver cases) (Obsolete)  
E = HMO out-of-plan services not emergency  
or urgently needed (Obsolete)  
E = MSP cost avoided - IRS/SSA/HCFR Data  
Match (eff. 7/00)  
F = MSP cost avoid HMO Rate Cell (eff. 7/00)  
G = MSP cost avoided Litigation Settlement  
(eff. 7/00)  
H = MSP cost avoided Employer Voluntary  
Reporting (eff. 7/00)  
J = MSP cost avoid Insurer Voluntary  
Reporting (eff. 7/00)  
K = MSP cost avoid Initial Enrollment  
Questionnaire (eff. 7/00)  
N = All other reasons for nonpayment  
P = Payment requested  
Q = MSP cost avoided Voluntary Agreement  
(eff. 7/00)  
R = Benefits refused, or evidence not  
submitted  
T = MSP cost avoided - IEQ contractor  
(eff. 9/76) (obsolete 6/30/00)  
U = MSP cost avoided - HMO rate cell  
adjustment (eff. 9/76) (Obsolete 6/30/00)  
V = MSP cost avoided - litigation  
settlement (eff. 9/76) (Obsolete 6/30/00)  
W = Worker's compensation (Obsolete)  
X = MSP cost avoided - generic  
Y = MSP cost avoided - IRS/SSA data  
match project (obsolete 6/30/00)  
Z = Zero reimbursement RAPs -- zero reimbursement  
made due to medical review intervention or  
where provider specific zero payment has been  
determined. (effective with HHPPS - 10/00)

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CLM\_OCRNC\_SPAN\_TB

Claim Occurrence Span Table

70 = Eff 10/93, payer use only, the  
nonutilization from/thru dates  
for PPS-inlier stay where bene had  
exhausted all full/coinsurance days, but

covered on cost report.  
SNF qualifying hospital stay from/thru dates  
71 = Hospital prior stay dates - the from/  
thru dates of any hospital stay that  
ended within 60 days of this hospital  
or SNF admission.  
72 = First/last visit - the dates of the  
first and last visits occurring in this  
billing period if the dates are different  
from those in the statement covers period.  
73 = Benefit eligibility period - the  
inclusive dates during which CHAMPUS  
medical benefits are available to a  
sponsor's bene as shown on the  
bene's ID card.  
74 = Non-covered level of care - The from/  
thru dates of a period at a noncovered  
level of care in an otherwise  
covered stay, excluding any period  
reported with occurrence span code 76,  
77, or 79.  
75 = The from/thru dates of SNF level of care  
during IP hospital stay. Shows PRO approval  
of patient remaining in hospital  
because SNF bed not available.  
not applicable to swing bed  
cases. PPS hospitals use in day  
outlier cases only.  
76 = Patient liability - From/thru  
dates of period of noncovered care  
for which hospital may charge  
bene. The FI or PRO must have  
approved such charges in advance.  
patient must be notified in writing  
3 days prior to noncovered period  
77 = Provider liability - The from/thru  
dates of period of noncovered care  
for which the provider is liable.  
Eff 3/92, applies to provider liability  
where bene is charged with utilization  
and is liable for deductible/coinsurance  
78 = SNF prior stay dates - The from/  
thru dates of any SNF stay that  
ended within 60 days of this hospital  
or SNF admission.  
79 = (Payer code) -  
Eff 3/92, from/thru dates of  
period of noncovered care where  
bene is not charged with utilization,  
deductible, or coinsurance.  
and provider is liable.  
Eff 9/93, noncovered period of care  
due to lack of medical necessity.

Claim Occurrence Span Table  
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80 - 99 = Reserved for state assignment  
M0 = PRO/UR approved stay dates - Eff 10/93,

the first and last days that were approved where not all of the stay was approved.

1 CLM\_PPS\_IND\_TB  
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Claim PPS Indicator Table  
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\*\*\*Effective NCH weekly process date 10/3/97 - 5/29/98\*\*\*

0 = not PPS bill (claim contains no PPS indicator)  
2 = PPS bill ( claim contains PPS indicator)

\*\*\*Effective NCH weekly process date 6/5/98\*\*\*

0 = not applicable (claim contains neither PPS nor deemed insured MQGE status indicators)  
1 = Deemed insured MQGE (claim contains deemed insured MQGE indicator but not PPS indicator)  
2 = PPS bill ( claim contains PPS indicator but no deemed insured MQGE status indicator)  
3 = Both PPS and deemed insured MQGE (contains both PPS and deemed insured MQGE indicators)

1 CLM\_RLT\_COND\_TB  
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Claim Related Condition Table  
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01 = Military service related - Medical condition incurred during military service.  
02 = Employment related - Patient alleged that the medical condition causing this episode of care was due to environment/ events resulting from employment.  
03 = Patient covered by insurance not reflected here - Indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill.  
04 = Health Maintenance Organization (HMO) enrollee - Medicare beneficiary is enrolled in an HMO. Eff 9/93, hospital must also expect to receive payment from HMO.  
05 = Lien has been filed - Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.  
06 = ESRD patient in 1st 18 months of entitlement covered by employer group health insurance - indicates Medicare may be secondary insurer. Eff 3/1/96, ESRD patient in 1st 30 months of entitlement covered by employer group health insurance.  
07 = Treatment of nonterminal condition for hospice patient - The patient is a hospice enrollee, but the provider is

- not treating a terminal condition and  
is requesting Medicare reimbursement.
- 08 = Beneficiary would not provide information  
concerning other insurance coverage.
- 09 = Neither patient nor spouse is employed  
- Code indicates that in response to  
development questions, the patient and  
spouse have denied employment.
- 10 = Patient and/or spouse is employed but  
no EGHP coverage exists or (eff 9/93)  
other employer sponsored/provided  
health insurance covering patient.
- 11 = The disabled beneficiary and/or family  
member has no group coverage from a LGHP  
or (eff 9/93) other employer  
sponsored/provided health insurance  
covering patient.
- 12 = Payer code - Reserved for internal  
use only by third party payers. HCFA  
will assign as needed. Providers will  
not report them.
- 13 = Payer code - Reserved for internal  
use only by third party payers. HCFA  
will assign as needed. Providers will  
not report them.
- 14 = Payer code - Reserved for internal  
Claim Related Condition Table
- use only by third party payers. HCFA  
will assign as needed. Providers will  
not report them.
- 15 = Clean claim (eff 10/92)
- 16 = SNF transition exemption - An  
exemption from the post-hospital  
requirement applies for this SNF stay  
or the qualifying stay dates are more  
than 30 days prior to the admission date
- 17 = Patient is over 100 years old - Code  
indicates that the patient was over  
100 years old at the date of admission.
- 18 = Maiden name retained - A dependent  
spouse entitled to benefits who does  
not use her husband's last name.
- 19 = Child retains mother's name - A  
patient who is a dependent child  
entitled to CHAMPVA benefits that does  
not have father's last name.
- 20 = Bene requested billing - Provider  
realizes the services on this bill are at a  
noncovered level of care or otherwise excluded  
from coverage, but the bene has requested  
formal determination
- 21 = Billing for denial notice - The SNF or HHA  
realizes services are at a noncovered level of  
care or excluded, but requests a Medicare denial  
in order to bill medicaid or other insurer
- 22 = Patient on multiple drug regimen - A

- patient who is receiving multiple intravenous drugs while on home IV therapy
- 23 = Homecaregiver available - The patient has a caregiver available to assist him or her during self-administration of an intravenous drug
- 24 = Home IV patient also receiving HHA services - the patient is under care of HHA while receiving home IV drug therapy services
- 25 = Reserved for national assignment
- 26 = VA eligible patient chooses to receive services in Medicare certified facility rather than a VA facility (eff 3/92)
- 27 = Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only). (eff 9/93)
- 28 = Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees. (eff 9/93)
- 29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for employer having fewer than 100 full and part-time employees

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Claim Related Condition Table  
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- 31 = Patient is student (full time - day) - Patient declares that he or she is enrolled as a full time day student.
- 32 = Patient is student (cooperative/work study program)
- 33 = Patient is student (full time - night) - Patient declares that he or she is enrolled as a full time night student.
- 34 = Patient is student (part time) - Patient declares that he or she is enrolled as a part time student.
- 36 = General care patient in a special unit - Patient is temporarily placed in special care unit bed because no general care beds were available.
- 37 = Ward accommodation is patient's request - Patient is assigned to ward accommodations at patient's request.
- 38 = Semi-private room not available - Indicates that either private or ward accommodations were assigned because semi-private accommodations were not available.
- 39 = Private room medically necessary - Patient needed a private room for medical reasons.

- 40 = Same day transfer - Patient transferred to another facility before midnight of the day of admission.
- 41 = Partial hospitalization - Eff 3/92, indicates claim is for partial hospitalization services. For OP services, this includes a variety of psych programs.
- 42 = Reserved for national assignment.
- 43 = Reserved for national assignment.
- 44 = Reserved for national assignment.
- 45 = Reserved for national assignment.
- 46 = Nonavailability statement on file for CHAMPUS claim for nonemergency IP care for CHAMPUS bene residing within the catchment area (usually a 40 mile radius) of a uniform services hospital.
- 47 = Reserved for CHAMPUS.
- 48 = Reserved for national assignment.
- 49 = Reserved for national assignment.
- 50 = Reserved for national assignment.
- 51 = Reserved for national assignment.
- 52 = Reserved for national assignment.
- 53 = Reserved for national assignment.
- 54 = Reserved for national assignment.
- 55 = SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
- 56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because

Claim Related Condition Table

- physical condition made it inappropriate to begin active care within that period
- 57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
  - 58 = Payment of SNF claims for beneficiaries disenrolling from terminating M+C plans plans who have not met the 3-day hospital stay requirement (eff. 10/1/00)
  - 59 = Reserved for national assignment.
  - 60 = Operating cost day outlier - PRICER indicates this bill is length of stay outlier (PPS)
  - 61 = Operating cost cost outlier - PRICER indicates this bill is a cost outlier (PPS)
  - 62 = PIP bill - This bill is a periodic interim payment bill.
  - 63 = PRO denial received before batch clearance report - The HCSSACL receipt date is used on PRO adjustment if the PRO's notification is before orig bill's acceptance

- report. (Payer only code eff 9/93)
- 64 = Other than clean claim - The claim is not a 'clean claim'
- 65 = Non-PPS code - The bill is not a prospective payment system bill.
- 66 = Outlier not claimed - Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS)
- 67 = Beneficiary elects not to use LTR days
- 68 = Beneficiary elects to use LTR days
- 69 = Operating IME Payment Only - providers request for IME payment for each discharge of MCO enrollee, beginning 1/1/98, from teaching hospitals (facilities with approved medical residency training program); not stored in NCH. Exception: problem in startup year may have resulted in this special IME payment request being erroneously stored in NCH. If present, disregard claim as condition code '69' is not valid NCH claim.
- 70 = Self-administered EPO - Billing is for a home dialysis patient who self administers EPO.
- 71 = Full care in unit - Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
- 72 = Self care in unit - Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
- 73 = Self care training - Billing is for special dialysis services where the

Claim Related Condition Table

- patient and helper (if necessary) were learning to perform dialysis.
- 74 = Home - Billing is for a patient who received dialysis services at home.
- 75 = Home 100% reimbursement - (not to be used for services after 4/15/90) The billing is for home dialysis patient using a dialysis machine that was purchased under the 100% program.
- 76 = Back-up facility - Billing is for a patient who received dialysis services in a back-up facility.
- 77 = Provider accepts or is obligated/required due to contractual agreement or law to accept payment by a primary payer as payment in full - Medicare pays nothing.
- 78 = New coverage not implemented by HMO - eff 3/92, indicates newly covered service under Medicare for which HMO

does not pay.

79 = CORF services provided off site -  
Code indicates that physical therapy,  
occupational therapy, or speech path-  
ology services were provided off site.

80 - 99 = Reserved for state assignment.

A0 = CHAMPUS external partnership program  
special program indicator code. (eff 10/93)

A1 = EPSDT/CHAP - Early and periodic  
screening diagnosis and treatment  
special program indicator code. (eff 10/93)

A2 = Physically handicapped children's  
program - Services provided receive  
special funding through Title 8 of  
the Social Security Act or the CHAMPUS  
program for the handicapped. (eff 10/93)

A3 = Special federal funding - Designed for  
uniform use by state uniform billing  
committees.  
Special program indicator code (eff 10/93)

A4 = Family planning - Designed for  
uniform use by state uniform billing  
committees.  
Special program indicator code (eff 10/93)

A5 = Disability - Designed for uniform  
use by state uniform billing  
committees.  
Special program indicator code (eff 10/93)

A6 = PPV/Medicare - Identifies that  
pneumococcal pneumonia 100% payment  
vaccine (PPV) services should be  
reimbursed under a special Medicare  
program provision.  
Special program indicator code (eff 10/93)

A7 = Induced abortion to avoid danger to  
woman's life.  
Special program indicator code (eff 10/93)

A8 = Induced abortion - Victim of rape/  
Claim Related Condition Table

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incest.  
Special program indicator code (eff 10/93)

A9 = Second opinion surgery - Services  
requested to support second opinion  
on surgery. Part B deductible and  
coinsurance do not apply.  
Special program indicator code (eff 10/93)

B0 = Special program indicator  
Reserved for national assignment.

B1 = Special program indicator  
Reserved for national assignment.

B2 = Special program indicator  
Reserved for national assignment.

B3 = Special program indicator  
Reserved for national assignment.

B4 = Special program indicator  
Reserved for national assignment.

B5 = Special program indicator  
Reserved for national assignment.  
B6 = Special program indicator  
Reserved for national assignment.  
B7 = Special program indicator  
Reserved for national assignment.  
B8 = Special program indicator  
Reserved for national assignment.  
B9 = Special program indicator  
Reserved for national assignment.  
C0 = Reserved for national assignment.  
C1 = Approved as billed - The services  
provided for this billing period have  
been reviewed by the PRO/UR or  
intermediary and are fully approved  
including any day or cost outlier. (eff 10/93)  
C2 = Automatic approval as billed based on  
focused review. (No longer used for  
Medicare)  
PRO approval indicator services (eff 10/93)  
C3 = Partial approval - The services  
provided for this billing period have  
been reviewed by the PRO/UR or  
intermediary and some portion has been  
denied (days or services). (eff 10/93)  
C4 = Admission/services denied - Indicates  
that all of the services were denied  
by the PRO/UR.  
PRO approval indicator services (eff 10/93)  
C5 = Postpayment review applicable - PRO/UR  
review to take place after payment.  
PRO approval indicator services (eff 10/93)  
C6 = Admission preauthorization - The  
PRO/UR authorized this admission/  
service but has not reviewed the  
services provided.  
PRO approval indicator services (eff 10/93)  
C7 = Extended authorization - the PRO has  
authorized these services for an  
extended length of time but has not  
reviewed the services provided.

Claim Related Condition Table  
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PRO approval indicator services (eff 10/93)  
C8 = Reserved for national assignment.  
PRO approval indicator services (eff 10/93)  
C9 = Reserved for national assignment.  
PRO approval indicator services (eff 10/93)  
D0 = Changes to service dates.  
Change condition (eff 10/93)  
D1 = Changes in charges.  
Change condition (eff 10/93)  
D2 = Changes in revenue codes/HCPSCS.  
Change condition (eff 10/93)  
D3 = Second or subsequent interim  
PPS bill.  
Change condition (eff 10/93)

D4 = Change in grouper input (diagnosis and/or procedures are changed resulting in a different DRG).  
Change condition (eff 10/93)  
D5 = Cancel only to correct a beneficiary claim account number or provider identification number.  
change condition (eff 10/93)  
D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an OP bill containing services required to be included on the IP bill). Change condition eff 10/93.  
D7 = Change to make Medicare the secondary payer.  
Change condition (eff 10/93)  
D8 = Change to make Medicare the primary payer.  
Change condition (eff 10/93)  
D9 = Any other change.  
Change condition (eff 10/93)  
E0 = Change in patient status.  
Change condition (eff 10/93)  
EY = National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study (eff. 11/97)  
G0 = Multiple medical visits occur on the same day in the same revenue center but visits are distinct and constitute independent visits (allows for payment under outpatient PPS -- eff. 7/3/00).  
M0 = All inclusive rate for outpatient services.  
(payer only code)  
M1 = Roster billed influenza virus vaccine.  
(payer only code)  
Eff 10/96, also includes pneumococcal pneumonia vaccine (PPV)  
M2 = HH override code - home health total reimbursement exceeds the \$150,000 cap or the number of total visits exceeds the 150 limitation. (eff 4/3/95)  
(payer only code)  
W0 = United Mine Workers of America (UMWA) SNF demonstration indicator (eff 1/97);

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Claim Related Condition Table

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but no claims transmitted until 2/98)

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Claim Related Occurrence Table

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01 = Auto accident - The date of an auto accident.  
02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable

- no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
- 03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
- 04 = Accident/employment related - The date of an accident relating to the patient's employment.
- 05 = Other accident - The date of an accident not described by the codes 01 thru 04.
- 06 = Crime victim - Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
- 07 = Reserved for national assignment.
- 08 = Reserved for national assignment.
- 11 = Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.
- 12 = Date of onset for a chronically dependent individual - Code indicates the date the patient/bene became a chronically dependent individual.
- 13 = Reserved for national assignment.
- 14 = Reserved for national assignment.
- 15 = Reserved for national assignment.
- 16 = Reserved for national assignment.
- 17 = Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed (eff 3/93)
- 18 = Date of retirement (patient/bene) - Code indicates the date of retirement for the patient/bene.
- 19 = Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.
- 20 = Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.
- 21 = UR notice received - Code indicating the date of receipt by the hospital of the UR committee's finding that the admission or future stay was not medically necessary.
- 22 = Active care ended - The date on which  
Claim Related Occurrence Table

a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis

- hospital. (For use by intermediary only)
- 23 = Reserved for national assignment  
(eff 10/93).  
Benefits exhausted - The last date  
for which benefits can be paid.  
(term 9/30/93; replaced by code A3)
- 24 = Date insurance denied - The date the  
insurer's denial of coverage was  
received by a higher priority payer.
- 25 = Date benefits terminated by primary  
payer - The date on which coverage  
(including worker's compensation benefits  
or no-fault coverage) is no longer  
available to the patient.
- 26 = Date skilled nursing facility (SNF)  
bed available - The date on which a SNF  
bed became available to a hospital  
inpatient who required only SNF level of  
care.
- 27 = Date home health plan established or  
last reviewed - Code indicating the  
date a home health plan of treatment  
was established or last reviewed.  
not used by hospital unless owner of facility
- 28 = Date comprehensive outpatient rehabi-  
litation plan established or last re-  
viewed - Code indicating the date a  
comprehensive outpatient rehabilitation  
plan was established or last reviewed.  
not used by hospital unless owner of facility
- 29 = Date OPT plan established or last  
reviewed - the date a plan of treatment  
was established for outpatient physical  
therapy.  
Not used by hospital unless owner of facility
- 30 = Date speech pathology plan treatment  
established or last reviewed - The date  
a speech pathology plan of treatment  
was established or last reviewed.  
Not used by hospital unless owner of facility
- 31 = Date bene notified of intent  
to bill (accommodations) - The date of  
the notice provided to the patient by  
the hospital stating that he no longer  
required a covered level of IP care.
- 32 = Date bene notified of intent  
to bill (procedures or treatment) - The  
date of the notice provided to the patient  
by the hospital stating requested care  
(diagnostic procedures or treatments) is  
not considered reasonable or necessary.
- 33 = First day of the Medicare coordination  
period for ESRD bene - During  
which Medicare benefits are secondary  
to benefits payable under an EGHP.
- Claim Related Occurrence Table

- Required only for ESRD beneficiaries.
- 34 = Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Christian Science Sanatoria only).
- 35 = Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.
- 36 = Date of discharge for the IP hospital stay when patient received a transplant procedure - Hospital is billing for immunosuppressive drugs.
- 37 = The date of discharge for the IP hospital stay when patient received a noncovered transplant procedure - Hospital is billing for immunosuppressive drugs.
- 38 = Date treatment started for home IV therapy - Date the patient was first treated in his home for IV therapy.
- 39 = Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.
- 40 = Scheduled date of admission - The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
- 41 = The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s).
- 42 = Date of discharge/termination of hospice care - for the final bill for hospice care. Eff 5/93, definition revised to apply only to date patient revoked hospice election.
- 43 = Reserved for national assignment.
- 44 = Date treatment started for occupational therapy - Code indicates the date services were initiated by the billing provider for occupational therapy.
- 45 = Date treatment started for speech therapy - Code indicates the date services were initiated by the billing provider for speech therapy.
- 46 = Date treatment started for cardiac rehabilitation - Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.
- 47 = Noncovered Outlier Stay Began- code

indicates the date that cost outlier status began and no Medicare payment will be made because all benefits have been exhausted during the inlier stay or the beneficiary does not elect to use life time reserve days (to be implemented in 1999).

- 48 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
- 49 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
- 50 - 69 = Reserved for state assignment
- A1 = Birthdate, Insured A - The birthdate of the individual in whose name the insurance is carried. (Eff 10/93)
- A2 = Effective date, Insured A policy - A code indicating the first date insurance is in force. (eff 10/93)
- A3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer A. (eff 10/93)
- B1 = Birthdate, Insured B - The birthdate of the individual in whose name the insurance is carried. (eff 10/93)
- B2 = Effective date, Insured B policy - A code indicating the first date insurance is in force. (eff 10/93)
- B3 = Benefits exhausted - code indicating the last date for which benefits are available and after which no payment can be made to payer B. (eff 10/93)
- C1 = Birthdate, Insured C - The birthdate of the individual in whose name the insurance is carried. (eff 10/93)
- C2 = Effective date, Insured C policy - A code indicating the first date insurance is in force. (eff 10/93)
- C3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer C. (eff 10/93)

\*\*For Inpatient/SNF Claims:\*\*

0 = ANOMALY: invalid value, if present, translate to '9'

- 1 = Physician referral - The patient was admitted upon the recommendation of a personal physician.
- 2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician.
- 3 = HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.
- 4 = Transfer from hospital - The patient was admitted as an inpatient transfer from an acute care facility.
- 5 = Transfer from a skilled nursing facility (SNF) - The patient was admitted as an inpatient transfer from a SNF.
- 6 = Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.
- 7 = Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician.
- 8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
- 9 = Information not available - The means by which the patient was admitted is not known.
- A = Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.

**\*\*For Newborn Type of Admission\*\***

- 1 = Normal delivery - A baby delivered with out complications.
- 2 = Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status.
- 3 = Sick baby - A baby delivered with medical complications, other than those relating to premature status.
- 4 = Extramural birth - A baby delivered in a nonsterile environment.
- 5-8 = Reserved for national assignment.

### Claim Source Of Inpatient Admission Table

9 = Information not available.

### Claim Service Classification Type Table

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For facility type code 1 thru 6, and 9

- 1 = Inpatient (including Part A)
- 2 = Hospital based or Inpatient (Part B only)  
or home health visits under Part B
- 3 = Outpatient (HHA-A also)
- 4 = Other (Part B)
- 5 = Intermediate care - level I
- 6 = Intermediate care - level II
- 7 = Subacute Inpatient  
(formerly Intermediate care - level III)
- 8 = Swing beds (used to indicate billing for  
SNF level of care in a hospital with an  
approved swing bed agreement)
- 9 = Reserved for national assignment

For facility type code 7

- 1 = Rural health
- 2 = Hospital based or independent renal  
dialysis facility
- 3 = Free-standing provider based federally  
qualified health center (eff 10/91)
- 4 = Other Rehabilitation Facility (ORF) and  
Community Mental Health Center (CMHC)  
(eff 10/91 - 3/97); ORF only (eff. 4/97)
- 5 = Comprehensive Rehabilitation Center  
(CORF)
- 6 = Community Mental Health Center (CMHC) (eff 4/97)
- 7-8 = Reserved for national assignment
- 9 = Other

For facility type code 8

- 1 = Hospice (non-hospital based)
- 2 = Hospice (hospital based)
- 3 = Ambulatory surgical center in hospital  
outpatient department
- 4 = Freestanding birthing center
- 5 = Critical Access Hospital (eff. 10/99)  
formerly Rural primary care hospital  
(eff. 10/94)
- 6-8 = Reserved for national use
- 9 = Other

- 0 = Religious NonMedical Health Care Institutions (RNHCI)  
bill (prior to 8/00, Christian Science bill), SNF bill,  
or state buy-in
- 1 = Psychiatric hospital facility bill or dummy psychiatric
- 2 = Tuberculosis hospital facility bill
- 3 = General care hospital facility bill or dummy LRD

4 = Regular SNF bill  
5 = Home health agency bill (HHA)  
6 = Outpatient hospital bill  
C = CORF bill - type of OP bill in the HHA bill format  
    (obsoleted 7/98)  
H = Hospice bill

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Claim Value Table  
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04 = Inpatient professional component charges which are combined billed - For use only by some all inclusive rate hospitals. (Eff 9/93)  
05 = Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.  
06 = Medicare blood deductible - Total cash blood deductible (Part A blood deductible).  
07 = Medicare cash deductible (term 9/30/93) reserved for national assignment. (eff 10/93)  
08 = Medicare Part A lifetime reserve amount in first calendar year - Lifetime reserve amount charged in the year of admission. (not stored in NCH until 2/93)  
09 = Medicare Part A coinsurance amount in the first calendar year - Coinsurance amount charged in the year of admission. (not stored in NCH until 2/93)  
10 = Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years. (not stored in NCH until 2/93)  
11 = Medicare Part A coinsurance amount in the second calendar year - Coinsurance amount charged in the year of discharge where the bill spans two calendar years (not stored in NCH until 2/93)  
12 = Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.  
13 = Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.

14 = That portion of payment from higher  
priority no fault auto/other  
liability insurance made on behalf of bene  
provider applied to Medicare covered  
services on this bill. Six zeroes indicate  
provider claimed conditional payment  
15 = That portion of a payment from a  
higher priority WC plan made on behalf  
of a bene that the provider applied to  
Claim Value Table  
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Medicare covered services on this bill. Six  
zeroes indicate the provider claimed  
conditional Medicare payment.  
16 = That portion of a payment from  
higher priority PHS or other federal  
agency made on behalf of a  
bene the provider applied  
to Medicare covered services on this  
bill. Six zeroes indicate  
provider claimed conditional Medicare  
payment.  
17 = Operating Outlier amount - Providers do  
not report this. For payer internal use  
only. Indicates the amount of day or  
cost outlier payment to be made.  
(Do not include any PPS capital outlier  
payment in this entry).  
18 = Operating Disproportionate share amount -  
Providers do not report this. For  
payer internal use only. Indicates the  
disproportionate share amount applicable  
to the bill. Use the amount provided by  
the disproportionate share field in PRICER.  
(Do not include any PPS capital DSH adjust-  
ment in this entry).  
19 = Operating Indirect medical education amount -  
Providers do not report this. For  
payer internal use only. Indicates the  
indirect medical education amount applicable  
to the bill. (Do not include PPS capital  
IME adjustment in this entry).  
20 = Total payment sent provider for capital  
under PPS, including HSP, FSP, outlier,  
old capital, DSH adjustment, IME  
adjustment, and any exception amount.  
(used 10/1/91 - 3/1/92 for provider  
reporting. Payer only code eff 9/93.)  
21 = Catastrophic - Medicaid - Eligibility  
requirements to be determined at state  
level. (Medicaid specific/deleted 9/93)  
22 = Surplus - Medicaid - Eligibility  
requirements to be determined at state  
level. (Medicaid specific/deleted 9/93)  
23 = Recurring monthly income - Medicaid -  
Eligibility requirements to be  
determined at state level. (Medicaid

- specific/deleted 9/93)
- 24 = Medicaid rate code - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
- 31 = Patient liability amount - Amount shown is that which you or the PRO approved to charge the bene for noncovered accommodations, diagnostic procedures or treatments.
- 37 = Pints of blood furnished - Total number of pints of whole blood or units
- Claim Value Table
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- of packed red cells furnished to the patient. (eff 10/93)
- 38 = Blood deductible pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. (eff 10/93)
- 39 = Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. (eff 10/93)
- 40 = New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO (eff 3/92). (use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO.)
- 41 = Amount is that portion of a payment from higher priority BL program made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 42 = Amount is that portion of a payment from higher priority VA made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 43 = Disabled bene under age 65 with LGHP - Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on this bill.
- 44 = Amount provider agreed to accept from primary payer when amount less than charges but more than payment received - When a lesser amount is received and the

- received amount is less than charges, a Medicare secondary payment is due.
- 46 = Number of grace days - Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post-discharge care. (eff 10/93)
- 47 = Any liability insurance - Amount is that portion from a higher priority liability insurance made on behalf of Medicare bene the provider is applying to Medicare covered services on this bill. (Eff 9/93)
- 48 = Hemoglobin reading - The latest  
Claim Value Table  
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- hemoglobin reading taken during this billing cycle.
- 49 = Latest hematocrit reading taken during billing cycle - Usually reported in two pos. (a percentage) to left of the dollar/cent delimiter. if provided with a decimal, use the 3rd pos. to right of the delimiter for the third digit.
- 50 = Physical therapy visits - Indicates the number of physical therapy visits from onset (at billing provider) through this billing period.
- 51 = Occupational therapy visits - Indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.
- 52 = Speech therapy visits - Indicates the number of speech therapy visits from onset (at billing provider) through this billing period.
- 53 = Cardiac rehabilitation - Indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period.
- 54 = Reserved for national assignment.
- 55 = Reserved for national assignment.
- 56 = Hours skilled nursing provided - The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.
- 57 = Home health visit hours - The number of home health aide services provided during the billing period. Count only the hours spent in the home.
- 58 = Arterial blood gas - Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and

- on the fourth month's bill.
- 59 = Oxygen saturation - Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill.
- 60 = HHA branch MSA - MSA in which HHA branch is located.
- 61 = Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider. (eff. 10/1/97)
- 62 = Number of Part A home health visits accrued during a period of continuous  
Claim Value Table  
-----
- care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 63 = Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 64 = Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 65 = Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 66 = Reserved for national assignment.
- 67 = Peritoneal dialysis - The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home). (eff. 10/97)
- 68 = EPO drug - Number of units of EPO administered relating to the billing period.
- 69 = Reserved for national assignment
- 70 = Interest amount - (Providers do not report this.) Report the amount applied to this bill.
- 71 = Funding of ESRD networks - (Providers do not report this.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.
- 72 = Flat rate surgery charge - Code indicates the amount of the charge for outpatient surgery where the hospital has such a charging structure.

- 73 = Drug deductible - (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.
- 74 = Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.
- 75 = Gramm/Rudman/Hollings - (Providers do not report this.) Report the amount of the sequestration applied to this bill.
- 76 = Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only)
- 77 = Payer code - This codes is set aside for payer use only. Providers do not report these codes.

Claim Value Table  
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- 78 = Payer code - This codes is set aside for payer use only. Providers do not report these codes.
- 79 = Payer code - This code is set aside for payer use only. Providers do not report these codes.
- 80 - 99 = Reserved for state assignment.
- A1 = Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07
- A2 = Coinsurance Payer A - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
- A4 = Self-administered drugs administered in an emergency situation - Ordinarily the only noncovered self-administered drug paid for under Medicare in an emergency situation is insulin administered to a patient in a diabetic coma. (eff 7/97)
- B1 = Deductible Payer B - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07
- B2 = Coinsurance Payer B - the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
- C1 = Deductible Payer C - The amount assumed by the provider to be applied to the patient's deductible amount

involving the indicated payer. (eff 10/93)  
- Prior value 07  
C2 = Coinsurance Payer C - The amount assumed  
by the provider to be applied to the  
patient's Part B coinsurance amount  
involving the indicated payer. (eff 10/93)  
Y1 = Part A demo payment - Portion of the  
payment designated as reimbursement for  
Part A services per the ORD contract. No  
deductible or coinsurance has been  
applied. (eff. 5/97)  
Y2 = Part B demo payment - Portion of the  
payment designated as reimbursement for  
Part B services for the ORD contract.  
No deductible or coinsurance has been  
applied. (eff. 5/97)  
Y3 = Part B coinsurance - Amount of Part B  
coinsurance applied by the intermediary  
to this demo claim. (eff. 5/97)  
Y4 = Conventional provider Part A payment -  
Amount Medicare would have reimbursed  
the provider for Part A services if  
there had been no demo. (eff. 5/97)

1 CTGRY\_EQTBL\_BENE\_IDENT\_TB Category Equatable Beneficiary Identification Code (BIC) Table  
-----

NCH BIC	SSA Categories
-----	-----
A	= A;J1;J2;J3;J4;M;M1;T;TA
B	= B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6; TB(F);TD(F);TE(F);TW(F)
B1	= B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M) TD(M);TE(M);TW(M)
B3	= B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2 W7;TG(F);TL(F);TR(F);TX(F)
B4	= B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M) TL(M);TR(M);TX(M)
B8	= B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4 W8;TH(F);TM(F);TS(F);TY(F)
BA	= BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9 WC;TJ(F);TN(F);TT(F);TZ(F)
BD	= BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF WJ;TK(F);TP(F);TU(F);TV(F)
BG	= BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M) TY(M)
BH	= BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M) TZ(M)
BJ	= BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M) TV(M)
C1	= C1;TC
C2	= C2;T2
C3	= C3;T3
C4	= C4;T4
C5	= C5;T5
C6	= C6;T6
C7	= C7;T7

C8 = C8;T8  
C9 = C9;T9  
F1 = F1;TF  
F2 = F2;TQ  
F3-F8 = Equatable only to itself (e.g., F3 IS  
equatable to F3)  
CA-CZ = Equatable only to itself. (e.g., CA is  
only equatable to CA)

-----  
RRB Categories

10 = 10  
11 = 11  
13 = 13;17  
14 = 14;16  
15 = 15  
43 = 43  
45 = 45  
46 = 46  
80 = 80  
83 = 83  
84 = 84;86  
85 = 85

1 DMERC\_LINE\_SCRN\_RSLT\_IND\_TB  
-----

DMERC Line Screen Result Indicator Table  
-----

A = Denied for lack of medical necessity;  
highest level of review was automated  
level I review  
B = Reduced (partially denied) for lack  
of medical necessity; highest level  
of review was automated level I review  
C = Denied as statutorily noncovered;  
highest level of review was automated  
level I review  
D = Reserved for future use  
E = Paid after automated level I review  
F = Denied for lack of medical necessity;  
highest level of review was manual  
level I review  
G = Reduced (partially denied) for lack  
of medical necessity; highest level  
of review was manual level I review  
H = Denied as statutorily noncovered;  
highest level of review was manual  
level I review  
I = Denied for coding/unbundling reasons;  
highest level of review was manual  
level I review  
J = Paid after manual level I review  
K = Denied for lack of medical necessity;  
highest level of review was manual  
level II review  
L = Reduced (partially denied) for lack  
of medical necessity; highest level

of review was manual level II review  
M = Denied as statutorily noncovered;  
highest level of review was manual  
level II review  
N = Denied for coding/unbundling reasons;  
highest level of review was manual  
level II review  
O = Paid after manual level II review  
P = Denied for lack of medical necessity;  
highest level of review was manual  
level III review  
Q = Reduced (partially denied) for lack  
of medical necessity; highest level  
of review was manual level III review  
R = Denied as statutorily noncovered;  
highest level of review was manual  
level III review  
S = Denied for coding/unbundling reasons;  
highest level of review was manual  
level III review  
T = Paid after manual level III review

1

DMERC\_LINE\_SUPLR\_TYPE\_TB

DMERC Line Supplier Type Table

0 = Clinics, groups, associations,  
partnerships, or other entities  
for whom the carrier's own ID number  
has been assigned.  
1 = Physicians or suppliers billing as  
solo practitioners for whom SSN's are  
shown in the physician ID code field.  
2 = Physicians or suppliers billing as  
solo practitioners for whom the carrier's  
own physician ID code is shown.  
3 = Suppliers (other than sole proprietorship)  
for whom EI numbers are used in coding the  
ID field.  
4 = Suppliers (other than sole proprietorship)  
for whom the carrier's own code has been  
shown.  
5 = Institutional providers and  
independent laboratories for whom EI  
numbers are used in coding the ID field.  
6 = Institutional providers and  
independent laboratories for whom the  
carrier's own ID number is shown.  
7 = Clinics, groups, associations, or  
partnerships for whom EI numbers  
are used in coding the ID field.  
8 = Other entities for whom EI numbers  
are used in coding the ID field or  
proprietorship for whom EI numbers are  
used in coding the ID field.

1

DRG\_OUTLIER\_STAY\_TB

Diagnosis Related Group Outlier Patient Stay Table

0 = No outlier

1 = Day outlier (condition code 60)  
2 = Cost outlier, (condition code 61)

\*\*\* Non-PPS Only \*\*\*

6 = Valid diagnosis related groups (DRG)  
received from the intermediary  
7 = HCFA developed DRG  
8 = HCFA developed DRG using patient status  
code  
9 = Not groupable

1

FI\_CLM\_ACTN\_TB

Fiscal Intermediary Claim Action Table

1 = Original debit action (includes non-adjustment RTI correction items) - it will always be a 1 in regular bills.  
2 = Cancel by credit adjustment - used only in credit/debit pairs (under HHPPS, updates the RAP).  
3 = Secondary debit adjustment - used only in credit/debit pairs (under HHPPS, would be the final claim or an adjustment on a LUPA).  
4 = Cancel only adjustment (under HHPPS, RAP/final claim/LUPA).  
5 = Force action code 3  
6 = Force action code 2  
8 = Benefits refused (for inpatient bills, an 'R' nonpayment code must also be present  
9 = Payment requested (used on bills that replace previously-submitted benefits-refused bills, action code 8. In such cases a debit/credit pair is not required. For inpatient bills, a 'P' should be entered in the nonpayment code.)

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FI\_NUM\_TB

Fiscal Intermediary Number Table

00010 = Alabama BC  
00020 = Arkansas BC  
00030 = Arizona BC  
00040 = California BC (term. 12/00)  
00050 = New Mexico BC/CO  
00060 = Connecticut BC  
00070 = Delaware BC - terminated 2/98  
00080 = Florida BC  
00090 = Florida BC  
00101 = Georgia BC  
00121 = Illinois - HCSC  
00123 = Michigan - HCSC  
00130 = Indiana BC/Administar Federal  
00131 = Illinois - Administar  
00140 = Iowa - Wellmark (term. 6/2000)

00150 = Kansas BC  
00160 = Kentucky/Administar  
00180 = Maine BC  
00181 = Maine BC - Massachusetts  
00190 = Maryland BC  
00200 = Massachusetts BC - terminated 7/97  
00210 = Michigan BC - terminated 9/94  
00220 = Minnesota BC  
00230 = Mississippi BC  
00231 = Mississippi BC/LA  
00232 = Mississippi BC  
00241 = Missouri BC - terminated 9/92  
00250 = Montana BC  
00260 = Nebraska BC  
00270 = New Hampshire/VT BC  
00280 = New Jersey BC (term. 8/2000)  
00290 = New Mexico BC - terminated 11/95  
00308 = Empire BC  
00310 = North Carolina BC  
00320 = North Dakota BC  
00332 = Community Mutual Ins Co; Ohio-Administar  
00340 = Oklahoma BC  
00350 = Oregon BC  
00351 = Oregon BC/ID.  
00355 = Oregon-CWF  
00362 = Independence BC - terminated 8/97  
00363 = Veritus, Inc (PITTS)  
00370 = Rhode Island BC  
00380 = South Carolina BC  
00390 = Tennessee BC  
00400 = Texas BC  
00410 = Utah BC  
00423 = Virginia BC; Trigon  
00430 = Washington/Alaska BC  
00450 = Wisconsin BC  
00452 = Michigan - Wisconsin BC  
00454 = United Government Services -  
Wisconsin BC (eff. 12/00)  
00460 = Wyoming BC  
00468 = N Carolina BC/CPRTIVA  
00993 = BC/BS Assoc.  
17120 = Hawaii Medical Service

1

FI\_NUM\_TB

Fiscal Intermediary Number Table

50333 = Travelers; Connecticut United Healthcare  
(terminated - date unknown)  
51051 = Aetna California - terminated 6/97  
51070 = Aetna Connecticut - terminated 6/97  
51100 = Aetna Florida - terminated 6/97  
51140 = Aetna Illinois - terminated 6/97  
51390 = Aetna Pennsylvania - terminated 6/97  
52280 = Mutual of Omaha  
57400 = Cooperative, San Juan, PR  
61000 = Aetna

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FI\_RQST\_CLM\_CNCL\_RSN\_TB

Claim Cancel Reason Code Table

C = Coverage Transfer  
D = Duplicate Billing  
H = Other or blank  
L = Combining two beneficiary master records  
P = Plan Transfer  
S = Scramble  
\*\*\*\*\*For Action Code 4 \*\*\*\*\*  
\*\*\*\*\*Effective with HHPPS - 10/00\*\*\*\*\*  
A = RAP/Final claim/LUPA is cancelled by Interme-  
diary. Does not delete episode. Do not set  
cancellation indicator.  
B = RAP/Final claim/LUPA is cancelled by Interme-  
diary. Does not delete episode. Set  
cancellation indicator to 1.  
E = RAP/Final claim/LUPA is cancelled by Interme-  
diary. Remove episode.  
F = RAP/Final claim/LUPA is cancelled by Provider.  
Remove episode.

1       GEO\_SSA\_STATE\_TB  
-----

State Table  
-----

- 01 = Alabama
- 02 = Alaska
- 03 = Arizona
- 04 = Arkansas
- 05 = California
- 06 = Colorado
- 07 = Connecticut
- 08 = Delaware
- 09 = District of Columbia
- 10 = Florida
- 11 = Georgia
- 12 = Hawaii
- 13 = Idaho
- 14 = Illinois
- 15 = Indiana
- 16 = Iowa
- 17 = Kansas
- 18 = Kentucky
- 19 = Louisiana
- 20 = Maine
- 21 = Maryland
- 22 = Massachusetts
- 23 = Michigan
- 24 = Minnesota
- 25 = Mississippi
- 26 = Missouri
- 27 = Montana
- 28 = Nebraska
- 29 = Nevada
- 30 = New Hampshire
- 31 = New Jersey
- 32 = New Mexico
- 33 = New York

1

GEO\_SSA\_STATE\_TB

-----

34 = North Carolina

35 = North Dakota

36 = Ohio

37 = Oklahoma

38 = Oregon

39 = Pennsylvania

40 = Puerto Rico

41 = Rhode Island

42 = South Carolina

43 = South Dakota

44 = Tennessee

45 = Texas

46 = Utah

47 = Vermont

48 = Virgin Islands

49 = Virginia

50 = Washington

51 = West Virginia

52 = Wisconsin

53 = Wyoming

54 = Africa

55 = Asia

56 = Canada & Islands

57 = Central America and West Indies

State Table

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HCFA\_PRVDR\_SPCLTY\_TB

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58 = Europe

59 = Mexico

60 = Oceania

61 = Philippines

62 = South America

63 = U.S. Possessions

64 = American Samoa

65 = Guam

66 = Saipan

97 = Northern Marianas

98 = Guam

99 = With 000 county code is American Samoa;

otherwise unknown

HCFA Provider Specialty Table

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\*\*Prior to 5/92\*\*

- 01 = General practice
- 02 = General surgery
- 03 = Allergy (revised 10/91 to mean allergy/immunology)
- 04 = Otology, laryngology, rhinology  
revised 10/91 to mean otolaryngology)
- 05 = Anesthesiology
- 06 = Cardiovascular disease (revised 10/91  
to mean cardiology)
- 07 = Dermatology
- 08 = Family practice

09 = Gynecology--osteopaths only (deleted  
10/91; changed to '16')  
10 = Gastroenterology  
11 = Internal medicine  
12 = Manipulative therapy (osteopaths only)  
(revised 10/91 to mean osteopathic  
manipulative therapy)  
13 = Neurology  
14 = Neurological surgery (revised 10/91 to  
mean neurosurgery)  
15 = Obstetrics--osteopaths only (deleted  
10/91; changed to '16')  
16 = OB-gynecology  
17 = Ophthalmology, otology, laryngology  
rhinology--osteopaths only (deleted  
10/91; changed to '18' if physicians  
practice is more than 50% ophthalmology  
or to '04' if physician's practice is  
more than 50% otolaryngology. If  
practice is 50/50, choose specialty  
with greater allowed charges.  
18 = Ophthalmology  
19 = Oral surgery (dentists only)  
20 = Orthopedic surgery  
21 = Pathologic anatomy, clinical pathology-  
osteopaths only (deleted 10/91;  
changed to '22')  
22 = Pathology  
23 = Peripheral vascular disease or surgery  
(deleted 10/91; changed to '76')  
24 = Plastic surgery (revised to mean  
plastic and reconstructive surgery).  
25 = Physical medicine and rehabilitation  
26 = Psychiatry  
27 = Psychiatry, neurology (osteopaths only)  
(deleted 10/91; changed to '86')  
28 = Proctology (revised 10/91 to mean  
colorectal surgery).  
29 = Pulmonary disease  
30 = Radiology (revised 10/91 to mean  
diagnostic radiology)  
31 = Roentgenology, radiology (osteopaths)  
(deleted 10/91; changed to '30')  
32 = Radiation therapy--osteopaths (deleted  
HCFA Provider Specialty Table

1 HCFA\_PRVDR\_SPCLTY\_TB  
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10/91; changed to '92')  
33 = Thoracic surgery  
34 = Urology  
35 = Chiropractor, licensed (revised 10/91  
to mean chiropractic)  
36 = Nuclear medicine  
37 = Pediatrics (revised 10/91 to mean  
pediatric medicine)  
38 = Geriatrics (revised 10/91 to mean  
geriatric medicine)  
39 = Nephrology

- 40 = Hand surgery
- 41 = Optometrist - services related to condition of aphakia (revised 10/91 to mean optometrist)
- 42 = Certified nurse midwife (added 7/88)
- 43 = Certified registered nurse anesthetist (revised 10/91 to mean CRNA, anesthesia assistant)
- 44 = Infectious disease
- 46 = Endocrinology (added 10/91)
- 48 = Podiatry - surgery chiropody (revised 10/91 to mean podiatry)
- 49 = Miscellaneous (include ASCS)
- 51 = Medical supply company with C.O. certification (certified orthotist - certified by American Board for Certification in Prosthetics and Orthotics).
- 52 = Medical supply company with C.P. certification (certified prosthetist - certified by American Board for Certification in Prosthetics and Orthotics).
- 53 = Medical supply company with C.P.O. certification (certified prosthetist - orthotist - certified by American Board for Certification in Prosthetics and Orthotics).
- 54 = Medical supply company not included in 51, 52, or 53.
- 55 = Individual certified orthotist
- 56 = Individual certified prosthetist
- 57 = Individual certified prosthetist - orthotist
- 58 = Individuals not included in 55,56 or 57
- 59 = Ambulance service supplier (e.g. private ambulance companies, funeral homes, etc.)
- 60 = Public health or welfare agencies (federal, state, and local)
- 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
- 62 = Psychologist--billing independently
- 63 = Portable X-ray supplier--billing independently (revised 10/91 to mean portable X-ray supplier)
- 64 = Audiologist (billing independently)
- 65 = Physical therapist (independent practice)
- 66 = Rheumatology (added 10/91)
- 67 = Occupational therapist--independent practice
- 68 = Clinical psychologist
- 69 = Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory --

billing independently)  
 70 = Clinic or other group practice, except  
 Group Practice Prepayment Plan (GPPP)  
 71 = Group Practice Prepayment Plan - diagnostic  
 X-ray (do not use after 1/92)  
 72 = Group Practice Prepayment Plan - diagnostic  
 laboratory (do not use after 1/92)  
 73 = Group Practice Prepayment Plan -  
 physiotherapy (do not use after 1/92)  
 74 = Group Practice Prepayment Plan - occupational  
 therapy (do not use after 1/92)  
 75 = Group Practice Prepayment Plan - other  
 medical care (do not use after 1/92)  
 76 = Peripheral vascular disease  
 (added 10/91)  
 77 = Vascular surgery (added 10/91)  
 78 = Cardiac surgery (added 10/91)  
 79 = Addiction medicine (added 10/91)  
 80 = Clinical social worker (1991)  
 81 = Critical care-intensivists (added 10/91)  
 82 = Ophthalmology, cataracts specialty  
 (added 10/91; used only until 5/92)  
 83 = Hematology/oncology (added 10/91)  
 84 = Preventive medicine (added 10/91)  
 85 = Maxillofacial surgery (added 10/91)  
 86 = Neuropsychiatry (added 10/91)  
 87 = All other (e.g. drug and department  
 stores) (revised 10/91 to mean all  
 other suppliers)  
 88 = Unknown (revised 10/91 to mean  
 physician assistant)  
 90 = Medical oncology (added 10/91)  
 91 = Surgical oncology (added 10/91)  
 92 = Radiation oncology (added 10/91)  
 93 = Emergency medicine (added 10/91)  
 94 = Interventional radiology (added 10/91)  
 95 = Independent physiological laboratory  
 (added 10/91)  
 96 = Unknown physician specialty  
 (added 10/91)  
 99 = Unknown--incl. social worker's  
 psychiatric services (revised 10/91 to  
 mean unknown supplier/provider)  
 -----  
 \*\*Effective 5/92\*\*

00 = Carrier wide  
01 = General practice  
02 = General surgery  
03 = Allergy/immunology

04 = Otolaryngology  
05 = Anesthesiology  
06 = Cardiology  
07 = Dermatology  
08 = Family practice

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1      HCFA_PRVDR_SPCLTY_TB
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HCFA Provider Specialty Table

- 09 = Gynecology (osteopaths only)  
(discontinued 5/92 use code 16)
- 10 = Gastroenterology
- 11 = Internal medicine
- 12 = Osteopathic manipulative therapy
- 13 = Neurology
- 14 = Neurosurgery
- 15 = Obstetrics (osteopaths only)  
(discontinued 5/92 use code 16)
- 16 = Obstetrics/gynecology
- 17 = Ophthalmology, otology, laryngology,  
rhinology (osteopaths only)  
(discontinued 5/92 use codes 18 or 04  
depending on percentage of practice)
- 18 = Ophthalmology
- 19 = Oral surgery (dentists only)
- 20 = Orthopedic surgery
- 21 = Pathologic anatomy, clinical  
pathology (osteopaths only)  
(discontinued 5/92 use code 22)
- 22 = Pathology
- 23 = Peripheral vascular disease, medical  
or surgical (osteopaths only)  
(discontinued 5/92 use code 76)
- 24 = Plastic and reconstructive surgery
- 25 = Physical medicine and rehabilitation
- 26 = Psychiatry
- 27 = Psychiatry, neurology (osteopaths  
only) (discontinued 5/92 use code 86)
- 28 = Colorectal surgery (formerly  
proctology)
- 29 = Pulmonary disease
- 30 = Diagnostic radiology
- 31 = Roentgenology, radiology (osteopaths  
only) (discontinued 5/92 use code 30)
- 32 = Radiation therapy (osteopaths only)  
(discontinued 5/92 use code 92)
- 33 = Thoracic surgery
- 34 = Urology
- 35 = Chiropractic
- 36 = Nuclear medicine
- 37 = Pediatric medicine
- 38 = Geriatric medicine
- 39 = Nephrology
- 40 = Hand surgery
- 41 = Optometry (revised 10/93 to  
mean optometrist)
- 42 = Certified nurse midwife (eff 1/87)
- 43 = Crna, anesthesia assistant  
(eff 1/87)
- 44 = Infectious disease
- 45 = Mammography screening center
- 46 = Endocrinology (eff 5/92)
- 47 = Independent Diagnostic Testing Facility  
(IDTF) (eff. 6/98)

- 48 = Podiatry
- 49 = Ambulatory surgical center  
(formerly miscellaneous)
- 50 = Nurse practitioner
- 51 = Medical supply company with  
certified orthotist (certified by  
American Board for Certification in  
Prosthetics And Orthotics)
- 52 = Medical supply company with  
certified prosthetist  
(certified by American Board for  
Certification In Prosthetics And  
Orthotics)
- 53 = Medical supply company with  
certified prosthetist-orthotist  
(certified by American Board for  
Certification in Prosthetics  
and Orthotics)
- 54 = Medical supply company not included  
in 51, 52, or 53. (Revised 10/93  
to mean medical supply company for DMERC)
- 55 = Individual certified orthotist
- 56 = Individual certified prosthetist
- 57 = Individual certified prosthetist-  
orthotist
- 58 = Individuals not included in 55, 56,  
or 57 (revised 10/93 to mean medical  
supply company with registered  
pharmacist)
- 59 = Ambulance service supplier, e.G.,  
private ambulance companies, funeral  
homes, etc.
- 60 = Public health or welfare agencies  
(federal, state, and local)
- 61 = Voluntary health or charitable  
agencies (e.G., National Cancer  
Society, National Heart Association,  
Catholic Charities)
- 62 = Psychologist (billing independently)
- 63 = Portable X-ray supplier
- 64 = Audiologist (billing independently)
- 65 = Physical therapist (independently  
practicing)
- 66 = Rheumatology (eff 5/92)  
Note: during 93/94 DMERC also used this  
to mean medical supply company with  
respiratory therapist
- 67 = Occupational therapist (independently  
practicing)
- 68 = Clinical psychologist
- 69 = Clinical laboratory (billing  
independently)
- 70 = Multispecialty clinic or group  
practice
- 71 = Diagnostic X-ray (GPPP) (not to  
be assigned after 5/92)

72 = Diagnostic laboratory (GPPP)  
(not to be assigned after 5/92)  
73 = Physiotherapy (GPPP) (not to be  
assigned after 5/92)  
74 = Occupational therapy (GPPP)  
(not to be assigned after 5/92)  
75 = Other medical care (GPPP) (not to  
assigned after 5/92)  
76 = Peripheral vascular disease  
(eff 5/92)  
77 = Vascular surgery (eff 5/92)  
78 = Cardiac surgery (eff 5/92)  
79 = Addiction medicine (eff 5/92)  
80 = Licensed clinical social worker  
81 = Critical care (intensivists)  
(eff 5/92)  
82 = Hematology (eff 5/92)  
83 = Hematology/oncology (eff 5/92)  
84 = Preventive medicine (eff 5/92)  
85 = Maxillofacial surgery (eff 5/92)  
86 = Neuropsychiatry (eff 5/92)  
87 = All other suppliers (e.g. drug and  
department stores) (note: DMERC used  
87 to mean department store from 10/93  
through 9/94; recoded eff 10/94 to A7;  
NCH cross-walked DMERC reported 87 to A7.  
88 = Unknown supplier/provider specialty  
(note: DMERC used 87 to mean grocery  
store from 10/93 - 9/94; recoded eff  
10/94 to A8; NCH cross-walked DMERC  
reported 88 to A8.  
89 = Certified clinical nurse specialist  
90 = Medical oncology (eff 5/92)  
91 = Surgical oncology (eff 5/92)  
92 = Radiation oncology (eff 5/92)  
93 = Emergency medicine (eff 5/92)  
94 = Interventional radiology (eff 5/92)  
95 = Independent physiological  
laboratory (eff 5/92)  
96 = Optician (eff 10/93)  
97 = Physician assistant (eff 5/92)  
98 = Gynecologist/oncologist (eff 10/94)  
99 = Unknown physician specialty  
A0 = Hospital (eff 10/93) (DMERCs only)  
A1 = SNF (eff 10/93) (DMERCs only)  
A2 = Intermediate care nursing facility  
(eff 10/93) (DMERCs only)  
A3 = Nursing facility, other (eff 10/93)  
(DMERCs only)  
A4 = HHA (eff 10/93) (DMERCs only)  
A5 = Pharmacy (eff 10/93) (DMERCs only)  
A6 = Medical supply company with respiratory  
therapist (eff 10/93) (DMERCs only)  
A7 = Department store (for DMERC use:  
eff 10/94, but cross-walked from  
code 87 eff 10/93)  
A8 = Grocery store (for DMERC use:

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HCFA\_PRVDR\_SPCLTY\_TB

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eff 10/94, but cross-walked from  
HCFA Provider Specialty Table

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code 88 eff 10/93)

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HCFA\_TYPE\_SRVC\_TB

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HCFA Type of Service Table

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- 1 = Medical care
- 2 = Surgery
- 3 = Consultation
- 4 = Diagnostic radiology
- 5 = Diagnostic laboratory
- 6 = Therapeutic radiology
- 7 = Anesthesia
- 8 = Assistant at surgery
- 9 = Other medical items or services
- 0 = Whole blood only eff 01/96,  
whole blood or packed red cells before 01/96
- A = Used durable medical equipment (DME)
- B = High risk screening mammography  
(obsolete 1/1/98)
- C = Low risk screening mammography  
(obsolete 1/1/98)
- D = Ambulance (eff 04/95)
- E = Enteral/parenteral nutrients/supplies  
(eff 04/95)
- F = Ambulatory surgical center (facility  
usage for surgical services)
- G = Immunosuppressive drugs
- H = Hospice services (discontinued 01/95)
- I = Purchase of DME (installment basis)  
(discontinued 04/95)
- J = Diabetic shoes (eff 04/95)
- K = Hearing items and services (eff 04/95)
- L = ESRD supplies (eff 04/95)  
(renal supplier in the home before 04/95)
- M = Monthly capitation payment for dialysis
- N = Kidney donor
- P = Lump sum purchase of DME, prosthetics,  
orthotics
- Q = Vision items or services
- R = Rental of DME
- S = Surgical dressings or other medical supplies  
(eff 04/95)
- T = Psychological therapy (term. 12/31/97)  
outpatient mental health limitation (eff. 1/1/98)
- U = Occupational therapy
- V = Pneumococcal/flu vaccine (eff 01/96),  
Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),  
Pneumococcal only before 04/95
- W = Physical therapy
- Y = Second opinion on elective surgery  
(obsoleted 1/97)
- Z = Third opinion on elective surgery  
(obsoleted 1/97)

1 LINE\_ADDTNL\_CLM\_DCMTN\_IND\_TB

Line Additional Claim Documentation Indicator Table

- 0 = No additional documentation
- 1 = Additional documentation submitted for non-DME EMC claim
- 2 = CMN/prescription/other documentation submitted which justifies medical necessity
- 3 = Prior authorization obtained and approved
- 4 = Prior authorization requested but not approved
- 5 = CMN/prescription/other documentation submitted but did not justify medical necessity
- 6 = CMN/prescription/other documentation submitted and approved after prior authorization rejected
- 7 = Recertification CMN/prescription/other documentation

1 LINE\_PLC\_SRVC\_TB

Line Place Of Service Table

- \*\*Prior To 1/92\*\*
- 1 = Office
  - 2 = Home
  - 3 = Inpatient hospital
  - 4 = SNF
  - 5 = Outpatient hospital
  - 6 = Independent lab
  - 7 = Other
  - 8 = Independent kidney disease treatment center
  - 9 = Ambulatory
  - A = Ambulance service
  - H = Hospice
  - M = Mental health, rural mental health
  - N = Nursing home
  - R = Rural codes

- \*\*Effective 1/92\*\*
- 11 = Office
  - 12 = Home
  - 21 = Inpatient hospital
  - 22 = Outpatient hospital
  - 23 = Emergency room - hospital
  - 24 = Ambulatory surgical center
  - 25 = Birthing center
  - 26 = Military treatment facility
  - 31 = Skilled nursing facility
  - 32 = Nursing facility
  - 33 = Custodial care facility
  - 34 = Hospice
  - 35 = Adult living care facilities (ALCF) (eff. NYD - added 12/3/97)
  - 41 = Ambulance - land

		42 = Ambulance - air or water
		50 = Federally qualified health centers (eff. 10/1/93)
		51 = Inpatient psychiatric facility
		52 = Psychiatric facility partial hospitalization
		53 = Community mental health center
		54 = Intermediate care facility/mentally retarded
		55 = Residential substance abuse treatment facility
		56 = Psychiatric residential treatment center
		60 = Mass immunizations center (eff. 9/1/97)
		61 = Comprehensive inpatient rehabilitation facility
		62 = Comprehensive outpatient rehabilitation facility
		65 = End stage renal disease treatment facility
		71 = State or local public health clinic
		72 = Rural health clinic
		81 = Independent laboratory
1	LINE_PLC_SRVC_TB -----	Line Place Of Service Table -----
		99 = Other unlisted facility
1	LINE_PMT_IND_TB -----	Line Payment Indicator Table -----
		1 = Actual charge
		2 = Customary charge
		3 = Prevailing charge (adjusted, unadjusted gap fill, etc)
		4 = Other (ASC fees, radiology and outpatient limits, and non-payment because of denial.
		5 = Lab fee schedule
		6 = Physician fee schedule - full fee schedule amount
		7 = Physician fee schedule - transition
		8 = Clinical psychologist fee schedule
		9 = DME and prosthetics/orthotics fee schedules (eff. 4/97)
1	LINE_PRCSG_IND_TB -----	Line Processing Indicator Table -----
		A = Allowed
		B = Benefits exhausted
		C = Noncovered care
		D = Denied (existed prior to 1991; from BMAD)
		I = Invalid data
		L = CLIA (eff 9/92)
		M = Multiple submittal--duplicate line item
		N = Medically unnecessary
		O = Other

P = Physician ownership denial (eff 3/92)  
Q = MSP cost avoided (contractor #88888) -  
voluntary agreement (eff. 1/98)  
R = Reprocessed--adjustments based on  
subsequent reprocessing of claim  
S = Secondary payer  
T = MSP cost avoided - IEQ contractor  
(eff. 7/76)  
U = MSP cost avoided - HMO rate cell  
adjustment (eff. 7/96)  
V = MSP cost avoided - litigation  
settlement (eff. 7/96)  
X = MSP cost avoided - generic  
Y = MSP cost avoided - IRS/SSA data  
match project  
Z = Bundled test, no payment  
(eff. 1/1/98)

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LINE\_PRVDR\_PRTCPTG\_IND\_TB

Line Provider Participating Indicator Table

1 = Participating  
2 = All or some covered and allowed  
expenses applied to deductible Participating  
3 = Assignment accepted/non-participating  
4 = Assignment not accepted/non-participating  
5 = Assignment accepted but all or some  
covered and allowed expenses applied  
to deductible Non-participating.  
6 = Assignment not accepted and all covered  
and allowed expenses applied to deductible  
non-participating.  
7 = Participating provider not accepting  
assignment.

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NCH\_CLM\_TYPE\_TB

NCH Claim Type Table

10 = HHA claim  
20 = Non swing bed SNF claim  
30 = Swing bed SNF claim  
40 = Outpatient claim  
41 = Outpatient 'Full-Encounter' claim  
(available in NMUD)  
42 = Outpatient 'Abbreviated-Encounter' claim  
(available in NMUD)  
50 = Hospice claim  
60 = Inpatient claim  
61 = Inpatient 'Full-Encounter' claim  
62 = Inpatient 'Abbreviated-Encounter' claim  
(available in NMUD)  
71 = RIC O local carrier non-DMEPOS claim  
72 = RIC O local carrier DMEPOS claim  
73 = Physician 'Full-Encounter' claim  
(available in NMUD)  
81 = RIC M DMERC non-DMEPOS claim

82 = RIC M DMERC DMEPOS claim

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NCH\_EDIT\_TB  
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NCH EDIT TABLE  
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A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE  
A000 = (C) REIMB > \$100,000 OR UNITS > 150  
A002 = (C) CLAIM IDENTIFIER (CAN)  
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)  
A004 = (C) PATIENT SURNAME BLANK  
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC  
A006 = (C) DATE OF BIRTH IS NOT NUMERIC  
A007 = (C) INVALID GENDER (0, 1, 2)  
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)  
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73  
A1X1 = (C) PERCENT ALLOWED INDICATOR  
A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589  
A1X3 = (C) DT>96365,DIAG=V725  
A1X4 = (C) INVALID DIAGNOSTIC CODES  
C050 = (U) HOSPICE - SPELL VALUE INVALID  
D102 = (C) DME DATE OF BIRTH INVALID  
D2X2 = (C) DME SCREEN SAVINGS INVALID  
D2X3 = (C) DME SCREEN RESULT INVALID  
D2X4 = (C) DME DECISION IND INVALID  
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID  
D3X1 = (C) DME NATIONAL DRUG CODE INVALID  
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID  
D4X2 = (C) DME OUT OF DMERC SERVICE AREA  
D4X3 = (C) DME STATE CODE INVALID  
D5X1 = (C) TOS INVALID FOR DME HCPCS  
D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING  
D5X3 = (C) DME INVALID USE OF MS MODIFIER  
D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED  
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS  
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID  
D6X1 = (C) DME SUPPLIER NUMBER MISSING  
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID  
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1  
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6  
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE  
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1  
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1  
Y003 = (C) HCPCS R0075/UNITS=SERVICES  
Y010 = (C) TOB=13X/14X AND T.C.>\$7,500  
Y011 = (C) INP CLAIM/REIM > \$75,000  
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76  
Z002 = (C) CC M2 PRESENT/REIMB > \$150,000  
Z003 = (C) CC M2 PRESENT/UNITS > 150  
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX  
Z005 = (C) REIMB>99999 AND REIMB<150000  
Z006 = (C) UNITS>99 AND UNITS<150  
Z237 = (E) HOSPICE OVERLAP - DATE ZERO  
0011 = (C) ACTION CODE INVALID  
0013 = (C) CABG/PCOE AND INVALID ADMIT DATE  
0014 = (C) DEMO NUM NOT=01-06,08,15,31  
0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15  
0016 = (C) INVALID VA CLAIM

0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08  
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5  
0020 = (C) CANCEL ONLY CODE INVALID  
0021 = (C) DEMO COUNT > 1  
0301 = (C) INVALID HI CLAIM NUMBER  
NCH EDIT TABLE  
-----  
  
0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK  
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)  
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC  
0401 = (C) BILL TYPE/PROVIDER INVALID  
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE  
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092  
0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66  
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974  
0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636  
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES  
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS  
0414 = (C) VALU CD 61,MSA AMOUNT MISSING  
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC  
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE  
05X5 = (C) UPIN REQUIRED FOR DME HCPCS  
0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK  
0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID  
0601 = (C) GENDER INVALID  
0701 = (C) CONTRACTOR INVALID CARRIER/ETC  
0702 = (C) PROVIDER NUMBER INCONSISTANT  
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE  
0704 = (C) INVALID CONT FOR CABG DEMO  
0705 = (C) INVALID CONT FOR PCOE DEMO  
0901 = (C) INVALID DISP CODE OF 02  
0902 = (C) INVALID DISP CODE OF SPACES  
0903 = (C) INVALID DISP CODE  
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE  
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE  
1301 = (C) LINE COUNT NOT NUMERIC OR > 13  
1302 = (C) RECORD LENGTH INVALID  
1401 = (C) INVALID MEDICARE STATUS CODE  
1501 = (C) ADMIT DATE/ENTRY CODE INVALID  
1502 = (C) ADMIT DATE > STAY FROM DATE  
1503 = (C) ADMIT DATE INVALID WITH THRU DATE  
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE  
1505 = (C) HCPCS W SERVICE DATES > 09-30-94  
1601 = (C) INVESTIGATION IND INVALID  
1701 = (C) SPLIT IND INVALID  
1801 = (C) PAY-DENY CODE INVALID  
1802 = (C) HEADER AMT AND NOT DENIED CLAIM  
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME  
1901 = (C) AB CROSSOVER IND INVALID  
2001 = (C) HOSPICE OVERRIDE INVALID  
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID  
2102 = (C) FROM/THRU DATE OR KRON/PAT STAT  
2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL  
2202 = (C) STAY-FROM DATE > THRU-DATE  
2203 = (C) THRU DATE INVALID  
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE  
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT

- 2207 = (C) MAMMOGRAPHY BEFORE 1991  
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID  
2302 = (C) COVERED DAYS INVALID OR INCONSIST  
2303 = (C) COST REPORT DAYS > ACCOMIDATION  
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL  
2305 = (C) UTIL DAYS = INCONSISTENCIES  
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT  
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09
- NCH EDIT TABLE  
-----
- 2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO  
2401 = (C) NON-UTIL DAYS INVALID  
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL  
2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE  
2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN  
2504 = (C) COINSURANCE AMOUNT EXCESSIVE  
2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT  
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST  
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR  
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN  
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES  
2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27  
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR  
2604 = (C) PPS BILL, NO DAY OUTLIER  
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.  
28XA = (C) UTIL DAYS > FROM TO BENEF EXH  
28XB = (C) BENEFITS EXH DATE > FROM DATE  
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE  
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP  
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)  
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)  
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS  
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE  
28XN = (C) INVALID OCC CODE  
28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES  
28X1 = (C) OCCUR DATE INVALID  
28X2 = (C) OCCUR = 20 AND TRANS = 4  
28X3 = (C) OCCUR 20 DATE < ADMIT DATE  
28X4 = (C) OCCUR 20 DATE > ADMIT + 12  
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM  
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE  
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE  
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU  
28X9 = (C) UTIL > FROM - THRU LESS NCOV  
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)  
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)  
33X3 = (C) QS DAYS/ADMISSION ARE INVALID  
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)  
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE  
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091  
33X7 = (C) TOB<>18/21/28/51,COND=WO  
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001  
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT  
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN  
3401 = (C) DEMO ID = 04 AND RIC NOT = 1  
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS  
35X2 = (C) COND = 60 OR 61 AND NO VALU 17

35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN MO  
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU  
3701 = (C) ASSIGN CODE INVALID  
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA  
3706 = (C) INVALID IDE NUMBER-NOT IN FILE  
3710 = (C) NUM OF IDE# > REV 0624  
3715 = (C) NUM OF IDE# < REV 0624  
3720 = (C) IDE AND LINE ITEM NUMBER > 2  
3801 = (C) AMT BENE PD INVALID  
4001 = (C) BLOOD PINTS FURNISHED INVALID  
4002 = (C) BLOOD FURNISHED/REPLACED INVALID  
NCH EDIT TABLE  
-----

4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT  
4201 = (C) BLOOD PINTS UNREPLACED INVALID  
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED  
4203 = (C) INVALID CPO PROVIDER NUMBER  
4301 = (C) BLOOD DEDUCTABLE INVALID  
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS  
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD  
4304 = (C) BLOOD DEDUCT > 3 - REPLACED  
4501 = (C) PRIMARY DIAGNOSIS INVALID  
46XA = (C) MSP VET AND VET AT MEDICARE  
46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)  
46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF  
46XG = (C) VALU CODE 20 INVALID  
46XN = (C) VALUE CODE 37,38,39 INVALID  
46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG  
46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS  
46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT  
46XR = (C) BLD FIELDS VS REV CDE 380,381,382  
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT  
46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0  
46X1 = (C) VALUE AMOUNT INVALID  
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO  
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)  
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT  
46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL  
46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61  
46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16  
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)  
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN  
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES  
4601 = (C) CABG/PCOE, MSP CODE PRESENT  
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7  
4901 = (C) PCOE/CABG,DEN CD NOT D  
4902 = (C) PCOE/CABG BUT DME  
50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85  
50X2 = (C) REV CD=054X,MOD NOT = QM,QN  
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS  
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD  
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER  
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274  
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER  
51XD = (C) HCPCS REQUIRES UNITS > ZERO  
51XE = (C) HCPCS REQUIRES REVENUE CODE 636  
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS

51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILLIA  
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044  
51XI = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045  
51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID  
51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX  
51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83  
51XM = (C) 21X,RC>9041/<9045,RC<>4/234  
51XN = (C) 21X,RC>9032/<9042,RC<>4/234  
51XP = (C) HHA RC DATE OF SRVC MISSING  
51XQ = (C) NO RC 0636 OR DTE INVALID  
51XR = (C) DEMO ID=01,RIC NOT=2  
51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21  
51X0 = (C) REV CENTER CODE INVALID  
51X1 = (C) REV CODE CHECK

51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE  
51X3 = (C) UNITS MUST BE > 0  
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR  
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE  
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO  
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85  
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID  
51X9 = (C) HCPCS/REV CODE/BILL TYPE  
5100 = (U) TRANSITION SPELL / SNF  
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0  
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR  
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT  
5169 = (U) PROVIDER NE TO WORK PROVIDER  
5177 = (U) PROVIDER NE TO WORK PROVIDER  
5178 = (U) HOSPICE BILL THRU < DOLBA  
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY  
5200 = (E) ENTITLEMENT EFFECTIVE DATE  
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90  
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE  
5202 = (U) HOSPICE TRAILER ERROR  
5203 = (E) ENTITLEMENT HOSPICE PERIODS  
5203 = (U) HOSPICE START DATE ERROR  
5204 = (U) HOSPICE DATE DIFFERENCE NE 90  
5205 = (U) HOSPICE DATE DISCREPANCY  
5206 = (U) HOSPICE DATE DISCREPANCY  
5207 = (U) HOSPICE THRU > TERM DATE 2ND  
5208 = (U) HOSPICE PERIOD NUMBER BLANK  
5209 = (U) HOSPICE DATE DISCREPANCY  
5210 = (E) ENTITLEMENT FRM/TRU/END DATES  
5211 = (E) ENTITLEMENT DATE DEATH/THRU  
5212 = (E) ENTITLEMENT DATE DEATH/THRU  
5213 = (E) ENTITLEMENT DATE DEATH MBR  
5220 = (E) ENTITLEMENT FROM/EFF DATES  
5225 = (E) ENT INP PPS SPAN 70 DATES  
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE  
5233 = (E) ENTITLEMENT HMO PERIODS  
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED  
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07  
5236 = (E) ENTITLEMENT HMO HOSP + CC07  
5237 = (E) ENTITLEMENT HOSP OVERLAP  
5238 = (U) HOSPICE CLAIM OVERLAP > 90

5239 = (U) HOSPICE CLAIM OVERLAP > 60  
524Z = (E) HOSP OVERLAP NO OVD NO DEMO  
5240 = (U) HOSPICE DAYS STAY+USED > 90  
5241 = (U) HOSPICE DAYS STAY+USED > 60  
5242 = (C) INVALID CARRIER FOR RRB  
5243 = (C) HMO=90091,INVALID SERVICE DTE  
5244 = (E) DEMO CABG/PCOE MISSING ENTL  
5245 = (C) INVALID CARRIER FOR NON RRB  
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO  
5250 = (U) HOSPICE DOEBA/DOLBA  
5255 = (U) HOSPICE DAYS USED  
5256 = (U) HOSPICE DAYS USED > 999  
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0  
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0  
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0  
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0  
5299 = (U) HOSPICE PERIOD NUMBER ERROR  
NCH EDIT TABLE  
-----

5320 = (U) BILL > DOEBA AND IND-1 = 2  
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY  
5355 = (U) HOSPICE DAYS USED SECONDARY  
5378 = (C) SERVICE DATE < AGE 50  
5399 = (U) HOSPICE PERIOD NUM MATCH  
5410 = (U) INPAT DEDUCTABLE  
5425 = (U) PART B DEDUCTABLE CHECK  
5430 = (U) PART B DEDUCTABLE CHECK  
5450 = (U) PART B COMPARE MED EXPENSE  
5460 = (U) PART B COMPARE MED EXPENSE  
5499 = (U) MED EXPENSE TRAILER MISSING  
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS  
5510 = (U) COIN DAYS/SNF COIN DAYS  
5515 = (U) FULL DAYS/COIN DAYS  
5516 = (U) SNF FULL DAYS/SNF COIN DAYS  
5520 = (U) LIFE RESERVE DAYS  
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS  
5540 = (U) HH VISITS NE AFT PT B TRLR  
5550 = (E) SNF LESS THAN PT A EFF DATE  
5600 = (D) LOGICAL DUPE, COVERED  
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123  
5602 = (D) LOGICAL DUPE, PANDE C, E OR I  
5603 = (D) LOGICAL DUPE, COVERED  
5605 = (D) POSS DUPE, OUTPAT REIMB  
5606 = (D) POSS DUPE, HOME HEALTH COVERED U  
5623 = (U) NON-PAY CODE IS P  
57X1 = (C) PROVIDER SPECIALITY CODE INVALID  
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL  
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND  
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID  
5700 = (U) LINKED TO THREE SPELLS  
5701 = (C) DEMO ID=02,RIC NOT = 5  
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM  
58X1 = (C) PROVIDER TYPE INVALID  
58X9 = (C) TYPE OF SERVICE INVALID  
5802 = (C) REIMB > \$150,000  
5803 = (C) UNITS/VISITS > 150  
5804 = (C) UNITS/VISITS > 99

59XA = (C) PROST ORTH HCPCS/FROM DATE  
59XB = (C) HCPCS/FROM DATE/TYPE P OR I  
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE  
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE  
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS  
59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS  
59XH = (C) HCPCS E0620/TYPE/DATE  
59XI = (C) HCPCS E0627-9/ DATE < 1991  
59XL = (C) HCPCS 00104 - TOS/POS  
59X1 = (C) INVALID HCPCS/TOS COMBINATION  
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID  
59X3 = (C) TOS INVALID TO MODIFIER  
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB  
59X5 = (C) MAMMOGRAPHY FOR MALE  
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS  
59X7 = (C) CAPPED-HCPCS/FROM DATE  
59X8 = (C) FREQUENTLY MAINTAINED HCPCS  
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R  
5901 = (U) ERROR CODE OF Q  
60X1 = (C) ASSIGN IND INVALID

NCH EDIT TABLE  
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6000 = (U) ADJUSTMENT BILL SPELL DATA  
6020 = (U) CURRENT SPELL DOEBA < 1990  
6030 = (U) ADJUSTMENT BILL SPELL DATA  
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA  
61X1 = (C) PAY PROCESS IND INVALID  
61X2 = (C) DENIED CLAIM/NO DENIED LINE  
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES  
61X4 = (C) RATE MISSING OR NON-NUMERIC  
6100 = (C) REV 0001 NOT PRESENT ON CLAIM  
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL  
6102 = (C) REV COMPUTED NON-COVERED/NON-COV  
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER  
62XA = (C) PSYC OT PT/REIM/TYPE  
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND  
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED  
62X8 = (C) KIDNEY DONO/TYPE/100%  
62X9 = (C) PNEUM VACCINE/TYPE/100%  
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV  
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE  
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA  
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS  
6261 = (U) HOSPICE ADJUSTMENT DAYS USED  
6265 = (U) HOSPICE ADJUSTMENT DAYS USED  
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)  
63X1 = (C) DEDUCT IND INVALID  
63X2 = (C) DED/HCFA COINS IN PCOE/CABG  
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS  
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)  
64X1 = (C) PROVIDER IND INVALID  
6430 = (U) PART B DEDUCTABLE CHECK  
65X1 = (C) PAYSCREEN IND INVALID  
66?? = (D) POSS DUPE, CR/DB, DOC-ID  
66XX = (D) POSS DUPE, CR/DB, DOC-ID  
66X1 = (C) UNITS AMOUNT INVALID  
66X2 = (C) UNITS IND > 0; AMT NOT VALID

66X3 = (C) UNITS IND = 0; AMT > 0  
66X4 = (C) MT INDICATOR/AMOUNT  
6600 = (U) ADJUSTMENT BILL FULL DAYS  
6610 = (U) ADJUSTMENT BILL COIN DAYS  
6620 = (U) ADJUSTMENT BILL LIFE RESERVE  
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
67X1 = (C) UNITS INDICATOR INVALID  
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0  
67X3 = (C) TOS/HPCPS=ANEST, MTU IND NOT = 2  
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1  
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST  
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD  
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN  
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS  
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS  
68X1 = (C) INVALID HCPCS CODE  
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092  
68X3 = (C) TYPE OF SERVICE = G /PROC CODE  
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE  
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC  
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC  
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.  
68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.  
NCH EDIT TABLE  
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69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL  
69X3 = (C) PROC CODE MOD = LL / TYPE = R  
69X6 = (C) PROC CODE MOD/NOT CAPPED  
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL  
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO  
6902 = (C) KRON IND AND NO-PAY CODE B OR N  
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0  
6904 = (C) KRON IND AND TRANS CODE IS 4  
6910 = (C) REV CODES ON HOME HEALTH  
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY  
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO  
6913 = (C) REV CODE INVAL FOR OXYGEN  
6914 = (C) REV CODE INVAL FOR DME  
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES  
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES  
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000  
6918 = (C) HCPCS INVALID ON DATE RANGES  
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89  
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33  
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X  
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274  
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291  
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL  
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X  
6929 = (U) ADJUSTMENT BILL LIFE RESERVE  
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
7000 = (U) INVALID DOEBA/DOLBA  
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS  
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD  
71X1 = (C) SUBMITTED CHARGES INVALID  
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG  
72X1 = (C) ALLOWED CHGS INVALID

72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE  
72X3 = (C) DENIED LINE/ALLOWED CHARGES  
73X1 = (C) SS NUMBER INVALID  
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING  
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT  
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL  
77X1 = (C) PLACE OF SERVICE INVALID  
77X2 = (C) PHYS THERAPY/PLACE  
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE  
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND  
77X6 = (C) TOS=F, PL OF SER NOT = 24  
7701 = (C) INCORRECT MODIFIER  
7777 = (D) POSS DUPE, PART B DOC-ID  
78XA = (C) MAMMOGRAPHY BEFORE 1991  
78X1 = (C) THRU DATE INVALID  
78X3 = (C) FROM DATE GREATER THAN THRU DATE  
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY  
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%  
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE  
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED  
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED  
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90  
8028 = (E) NO ENTITLEMENT  
8029 = (U) HH BEFORE PERIOD NOT PRESENT  
8030 = (U) HH BILL VISITS > PT A REMAINING  
8031 = (U) HH PT A REMAINING > 0

NCH EDIT TABLE  
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8032 = (U) HH DOLBA+59 NOT GT FROM-DATE  
8050 = (U) HH QUALIFYING INDICATOR = 1  
8051 = (U) HH # VISITS NE AFT PT B APPLIED  
8052 = (U) HH # VISITS NE AFT TRAILER  
8053 = (U) HH BENEFIT PERIOD NOT PRESENT  
8054 = (U) HH DOEBA/DOLBA NOT > 0  
8060 = (U) HH QUALIFYING INDICATOR NE 1  
8061 = (U) HH DATE NE DOLBA IN AFT TRLR  
8062 = (U) HH NE PT-A VISITS REMAINING  
81X1 = (C) NUM OF SERVICES INVALID  
83X1 = (C) DIAGNOSIS INVALID  
8301 = (C) HCPCS/GENDER DIAGNOSIS  
8302 = (C) HCPCS G0101 V-CODE/SEX CODE  
8304 = (C) BILL TYPE INVALID FOR G0123/4  
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC  
84X2 = (C) INVALID DME START DATE  
84X3 = (C) INVALID DME START DATE W/HCPCS  
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE  
84X5 = (C) HCPCS CODE WITH INV DIAG CODE  
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS  
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD  
9000 = (U) DOEBA/DOLBA CALC  
9005 = (U) FULL/COINS HOSP DAYS CALC  
9010 = (U) FULL/COINS SNF DAYS CALC  
9015 = (U) LIFE RESERVE DAYS CALC  
9020 = (U) LIFE PSYCH DAYS CALC  
9030 = (U) INPAT DEDUCTABLE CALC  
9040 = (U) DATA INDICATOR 1 SET  
9050 = (U) DATA INDICATOR 2 SET

91X1	=	(C)	PATIENT REIMB/PAY-DENY CODE
92X1	=	(C)	PATIENT REIMB INVALID
92X2	=	(C)	PROVIDER REIMB INVALID
92X3	=	(C)	LINE DENIED/PATIENT-PROV REIMB
92X4	=	(C)	MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5	=	(C)	CHARGES/REIMB AMT NOT CONSISTANT
92X7	=	(C)	REIMB/PAY-DENY INCONSISTANT
9201	=	(C)	UPIN REF NAME OR INITIAL MISSING
9202	=	(C)	UPIN REF FIRST 3 CHAR INVALID
9203	=	(C)	UPIN REF LAST 3 CHAR NOT NUMERIC
93X1	=	(C)	CASH DEDUCTABLE INVALID
93X2	=	(C)	DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3	=	(C)	DENIED LINE/CASH DEDUCTIBLE
93X4	=	(C)	FROM DATE/CASH DEDUCTIBLE
93X5	=	(C)	TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300	=	(C)	UPIN OTHER, NOT PRESENT
9301	=	(C)	UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302	=	(C)	UPIN OPERATING, FIRST 3 NOT NUMERIC
9303	=	(C)	UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1	=	(C)	NON-COVERED FROM DATE INVALID
94A2	=	(C)	NON-COVERED FROM > THRU DATE
94A3	=	(C)	NON-COVERED THRU DATE INVALID
94A4	=	(C)	NON-COVERED THRU DATE > ADMIT
94A5	=	(C)	NON-COVERED THRU DATE/ADMIT DATE
94C1	=	(C)	PR-PSYCH DAYS INVALID
94C3	=	(C)	PR-PSYCH DAYS > PROVIDER LIMIT
94F1	=	(C)	REIMBURSEMENT AMOUNT INVALID
94F2	=	(C)	REIMBURSE AMT NOT 0 FOR HMO PAID
94G1	=	(C)	NO-PAY CODE INVALID
NCH EDIT TABLE			
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94G2	=	(C)	NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3	=	(C)	NO-PAY/PROVIDER INCONSISTANT
94G4	=	(C)	NO PAY CODE = R & REIMB PRESENT
94X1	=	(C)	BLOOD LIMIT INVALID
94X2	=	(C)	TYPE/BLOOD DEDUCTIBLE
94X3	=	(C)	TYPE/DATE/LIMIT AMOUNT
94X4	=	(C)	BLOOD DED/TYPE/NUMBER OF SERVICES
94X5	=	(C)	BLOOD/MSP CODE/COMPUTED LINE MAX
9401	=	(C)	BLOOD DEDUCTIBLE AMT > 3
9402	=	(C)	BLOOD FURNISHED > DEDUCTIBLE
9403	=	(C)	DATE OF BIRTH MISSING ON PRO-PAY
9404	=	(C)	INVALID GENDER CODE ON PRO-PAY
9407	=	(C)	INVALID DRG NUMBER
9408	=	(C)	INVALID DRG NUMBER (GLOBAL)
9409	=	(C)	HCFA DRG<>DRG ON BILL
9410	=	(C)	CABG/PCOE,INVALID DRG
95X1	=	(C)	MSP CODE G/DATE BEFORE 1/1/87
95X2	=	(C)	MSP AMOUNT APPLIED INVALID
95X3	=	(C)	MSP AMOUNT APPLIED > SUB CHARGES
95X4	=	(C)	MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5	=	(C)	MSP CODE = G/DATE BEFORE 1987
95X6	=	(C)	MSP CODE = X AND NOT AVOIDED
95X7	=	(C)	MSP CODE VALID, CABG/PCOE
96X1	=	(C)	OTHER AMOUNTS INVALID
96X2	=	(C)	OTHER AMOUNTS > PAT-PROV REIMB
97X1	=	(C)	OTHER AMOUNTS INDICATOR INVALID

97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0  
98X1 = (C) COINSURANCE INVALID  
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH  
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI  
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP  
99XX = (D) POSS DUPE, PART B DOC-ID  
9901 = (C) REV CODE INVALID OR TRAILER CNT=0  
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE  
9903 = (C) NO CLINIC VISITS FOR RHC  
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE  
991X = (C) NO DATE OF SERVICE  
9910 = (C) EDIT 9910 (NEW)  
9911 = (C) BLOOD VERIFIED INVALID  
9920 = (C) EDIT 9920 (NEW)  
9930 = (C) EDIT 9930 (NEW)  
9931 = (C) OUTPAT COINSURANCE VALUES  
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT  
9940 = (C) EDIT 9940 (NEW)  
9942 = (C) EDIT 9942 (NEW)  
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612  
9945 = (C) SERVICE DATE < 98001  
9946 = (C) INVALID DIAGNOSIS CODE  
9947 = (C) INVALID DIAGNOSIS CODE  
9948 = (C) STAY FROM>96365,DIAG=V725  
9960 = (C) MED CHOICE BUT HMO DATA MISSING  
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING  
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER

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NCH\_IP\_PRO\_APRVL\_TYPE\_TB

NCH Inpatient Peer Review Organization Approval Type Table

- 1 = Approved by the PRO as billed - Code indicates that the claim has been reviewed by the PRO and has been fully approved including any day or cost outliers.
- 2 = Automatic approval - Does not apply to Medicare claim.
- 3 = Partial approval - Code indicates the bill has been reviewed by the PRO, and some portion (days or services) has been denied. The from/thru dates of the approved portion of the stay, excluding grace days and any period at a noncovered level of care are shown on the bill.
- 4 = Admission denied - Code indicates the patient's need for inpatient services was reviewed upon admission and the PRO found that the stay was not medically necessary.
- 5 = Post payment review - Code indicates that any medical review will be completed after the claim is paid. The bill may be a day outlier, part of the sample review, or may not be reviewed.

6 = Pre-admission authorization - Pre-admission authorization obtained, but services not reviewed by the PRO.  
7 THRU 9 = Reserved.

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NCH\_NEAR\_LINE\_RIC\_TB

NCH Near-Line Record Identification Code Table

O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)  
V = Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)  
W = Part B institutional claim record (outpatient (OP), HHA)  
U = Both Part A and B institutional home health agency (HHA) claim records -- due to HHPPS and HHA A/B split. (effective 10/00)  
M = Part B DMEPOS claim record (processed by DME Regional Carrier) (effective 10/93)

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NCH\_PATCH\_TB

NCH Patch Table

01 = RRB Category Equatable BIC - changed (all claim types) -- applied during the Nearline 'G' conversion to claims with NCH weekly process date before 3/91. Prior to Version 'H', patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 2.  
02 = Claim Transaction Code made consistent with NCH payment/edit RIC code (OP and HHA) -- effective 3/94, CWFMQA began patch. During 'H' conversion, patch applied to claims with NCH weekly process date prior to 3/94. Prior to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.  
03 = Garbage/nonnumeric Claim Total Charge Amount set to zeroes (Instnl) -- during the Version 'G' conversion, error occurred in the derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' ocnversion, patch applied to Nearline claims where garbage or nonnumeric values.  
04 = Incorrect bene residence SSA standard county code '999' changed (all claim types) -- applied during the Nearline 'G' conversion and ongoing through 4/21/94, calling EQSTZIP

routine to claims with NCH weekly process date prior to 4/22/94. Prior to Version 'H' patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 4.

05 = Wrong century bene birth date corrected (all claim types) -- applied during Nearline 'H' conversion to all history where century greater than 1700 and less than 1850; if century less than 1700, zeroes moved.

06 = Inconsistent CWF bene medicare status code made consistent with age (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing. Bene age is calculated to determine the correct value; if greater than 64, 1st position MSC ='1'; if less than 65, 1st position MSC = '2'.

07 = Missing CWF bene mediare status code derived (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing, except claims with unknown DOB and/or Claim From Date='0' (left blank). Bene age is calculated to determine missing value; if greater than 64, MSC='10'; if less than 65, MSC = '20'.

08 = Invalid NCH primary payer code set to blanks (Instnl) -- applied during Version 'H' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values =  
NCH Patch Table  
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invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).

09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types) -- applied during Version 'H' conversion to Instnl and DMERC claims; applied during Version 'G' conversion to non-institutional (non-DMERC) claims. Prior to Version 'H', patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.

10 = Multiple Revenue Center 0001 (Outpatient, HHA and Hospice) -- patch applied to 1998 & 1999 Nearline and SAFs to delete any revenue codes that followed the first '0001' revenue center code. The edit was applied across all institutional claim types, including Inpatient/SNF (the problem was only found with OP/HHA/Hospice claims). The problem was corrected 6/25/99.

11 = Truncated claim total charge amount in the fixed portion replaced with the total charge amount in the revenue center 0001 amount field -- service years 1998 & 1999 patched during quarterly merge. The 1998 & 1999 SAFs were corrected when finalized in 7/99. The patch was done for records with NCH Daily Process

- Date 1/4/99 - 5/14/99.
- 12 = Missing claim-level HHA Total Visit Count -- service years 1998, 1999 & 2000 patch applied during Version 'I' conversion of both the Nearline and SAFs. Problem occurs in those claims recovered during the missing claims effort.
- 13 = Inconsistent Claim MCO Paid Switch made consistent with criteria used to identify an inpatient encounter claim -- if MCO paid switch equal to blank or '0' and ALL conditions are met to indicate an inpatient encounter claim (bene enrolled in a risk MCO during the service period), change the switch to a '1'. The patch was applied during the Version 'I' conversion, for claims back to 7/1/97 service thru date.

1 NCH\_STATE\_SGMT\_TB  
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NCH State Segment Table  
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- 01 = Alabama  
02 = Alaska  
03 = Arizona  
04 = Arkansas  
05 = California  
06 = Colorado  
07 = Connecticut  
08 = Delaware  
09 = District of Columbia  
10 = Florida  
11 = Georgia  
12 = Hawaii  
13 = Idaho  
14 = Illinois  
15 = Indiana  
16 = Iowa  
17 = Kansas  
18 = Kentucky  
19 = Louisiana  
20 = Maine  
21 = Maryland  
22 = Massachusetts  
23 = Michigan  
24 = Minnesota  
25 = Mississippi  
26 = Missouri  
27 = Montana  
28 = Nebraska  
29 = Nevada  
30 = New Hampshire  
31 = New Jersey  
32 = New Mexico  
33 = New York  
34 = North Carolina  
35 = North Dakota  
36 = Ohio  
37 = Oklahoma  
38 = Oregon  
39 = Pennsylvania

1	NCH_STATE_SGMT_TB	-----	40 = Puerto Rico 41 = Rhode Island 42 = South Carolina 43 = South Dakota 44 = Tennessee 45 = Texas 46 = Utah 47 = Vermont 48 = Virgin Islands 49 = Virginia 50 = Washington 51 = West Virginia 52 = Wisconsin 53 = Wyoming 54 = Africa 55 = Asia 56 = Canada 57 = Central America & West Indies	NCH State Segment Table	-----
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58 = Europe  
59 = Mexico  
60 = Oceania  
61 = Philippines  
62 = South America  
63 = US Possessions  
97 = Saipan - MP  
98 = Guam  
99 = American Samoa

1	PRVDR_NUM_TB	-----	Provider Number Table	-----
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- First two positions are the GEO SSA State Code.  
Exception: 55 = California  
67 = Texas  
68 = Florida
- Positions 3 and sometimes 4 are used as a category identifier. The remaining positions are serial numbers. The following blocks of numbers are reserved for the facilities indicated (NOTE: may have different meanings dependent on the Type of Bill (TOB)):  
  
0001-0879 Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X  
0880-0899 Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X  
0900-0999 Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X

1000-1199	Reserved for future use
1200-1224	Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1225-1299	Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X
1300-1399	Rural Primary Care Hospital (RCPH) - eff. 10/97 changed to Critical Access Hospitals (CAH)
1400-1499	Continuation of 4900-4999 series (CMHC)
1500-1799	Hospices
1800-1989	Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X
1990-1999	Christian Science Sanatoria (hospital services)
2000-2299	Long-term hospitals (excluded from PPS)
2300-2499	Chronic renal disease facilities (hospital based)
2500-2899	Non-hospital renal disease treatment centers
2900-2999	Independent special purpose renal dialysis facility (1)
3000-3024	Formerly tuberculosis hospitals (numbers retired)
3025-3099	Rehabilitation hospitals (excluded from PPS)
3100-3199	Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3) (eff. 4/96)
3200-3299	Continuation of 4800-4899 series (CORF) Provider Number Table
3300-3399	Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X
3400-3499	Continuation of rural health clinics (provider-based) (3975-3999)
3500-3699	Renal disease treatment centers (hospital satellites)
3700-3799	Hospital based special purpose renal dialysis facility (1)
3800-3974	Rural health clinics (free-standing)
3975-3999	Rural health clinics (provider-based)
4000-4499	Psychiatric hospitals (excluded from PPS)
4500-4599	Comprehensive Outpatient Rehabilitation Facilities (CORF)
4600-4799	Community Mental Health Centers (CMHC); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
4800-4899	Continuation of 4500-4599 series (CORF) (eff. 10/95)
4900-4999	Continuation of 4600-4799 series (CMHC)

(eff. 10/95); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X  
5000-6499 Skilled Nursing Facilities  
6500-6989 CMHC / Outpatient physical therapy services where TOB = 74X; CORF where TOB = 75X  
6990-6999 Christian Science Sanatoria (skilled nursing services)  
7000-7299 Home Health Agencies (HHA) (2)  
7300-7399 Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)  
7400-7799 Continuation of 7000-7299 series  
7800-7999 Subunits of state and local governmental Home Health Agencies (3)  
8000-8499 Continuation of 7400-7799 series (HHA)  
8500-8899 Continuation of rural health center (provider based) (3400-3499)  
8900-8999 Continuation of rural health center (free-standing) (3800-3974)  
9000-9499 Continuation of 8000-8499 series (HHA) (eff. 10/95)  
9500-9999 Reserved for future use (eff. 8/1/98)  
NOTE: 10/95-7/98 this series was assigned to HHA's but rescinded - no HHA's were ever assigned a number from this series.

Exception:

P001-P999 Organ procurement organization

- (1) These facilities (SPRDFS) will be assigned the same provider number whenever they are recertified.
- (2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45)
- Provider Number Table
- have been used in reducing acute care costs (RACC) experiments.
- (3) In Virginia (49), the series 7100-7299 has been reserved for statewide subunit components of the Virginia state home health agencies.
- (4) Parent agency must have a number in the 7000-7299, 7400-7799 or 8000-8499 series.

NOTE:

There is a special numbering system for units of hospitals that are excluded from prospective payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

S = Psychiatric unit (excluded from PPS)  
T = Rehabilitation unit (excluded from PPS)  
U = Short term/acute care swing-bed hospital  
V = Alcohol drug unit (prior to 10/87 only)  
W = Long term SNF swing-bed hospital  
    (eff 3/91)  
Y = Rehab hospital swing-bed (eff 9/92)  
Z = Rural primary care swing-bed hospital

There is also a special numbering system for assigning emergency hospital identification numbers (non participating hospitals). The sixth position of the provider number is as follows:

E = Non-federal emergency hospital  
F = Federal emergency hospital

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PTNT\_DSCHRG\_STUS\_TB

Patient Discharge Status Table

- 01 = Discharged to home/self care (routine charge).
- 02 = Discharged/transferred to other short term general hospital for inpatient care.
- 03 = Discharged/transferred to skilled nursing facility (SNF) - (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.
- 04 = Discharged/transferred to intermediate care facility (ICF).
- 05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).
- 06 = Discharged/transferred to home care of organized home health service organization.
- 07 = Left against medical advice or discontinued care.
- 08 = Discharged/transferred to home under care of a home IV drug therapy provider.
- 09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
- 20 = Expired (did not recover - Christian Science patient).
- 30 = Still patient.
- 40 = Expired at home (hospice claims only)
- 41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
- 42 = Expired - place unknown (Hospice claims

only)  
50 = Hospice - home (eff. 10/96)  
51 = Hospice - medical facility (eff. 10/96)  
61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (to be implemented in 1999)  
71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).  
72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).

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REV\_CNTR\_ANSI\_TB  
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Revenue Center ANSI Code Table  
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\*\*\*\*\*EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES\*\*\*\*\*  
\*\*\*\*\*POSITIONS 1 & 2 OF ANSI CODE\*\*\*\*\*

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

\*\*\*\*\*Claim Adjustment Reason Codes\*\*\*\*\*  
\*\*\*\*\*POSITIONS 3 through 5 of ANSI CODE\*\*\*\*\*

1 = Deductible Amount  
2 = Coinsurance Amount  
3 = Co-pay Amount  
4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.

- 5 = The procedure code/bill type is inconsistent with the place of service.
  - 6 = The procedure code is inconsistent with the patient's age.
  - 7 = The procedure code is inconsistent with the patient's gender.
  - 8 = The procedure code is inconsistent with the provider type.
  - 9 = The diagnosis is inconsistent with the patient's age.
  - 10 = The diagnosis is inconsistent with the patient's gender.
  - 11 = The diagnosis is inconsistent with the procedure.
  - 12 = The diagnosis is inconsistent with the provider type.
  - 13 = the date of death precedes the date of service.
  - 14 = The date of birth follows the date of service.
  - 15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
  - 16 = Claim/service lacks information which is needed for Revenue Center ANSI Code Table
- 

- adjudication.
- 17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.
  - 18 = Duplicate claim/service.
  - 19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
  - 20 = Claim denied because this injury/illness is covered by the liability carrier.
  - 21 = Claim denied because this injury/illness is the liability of the no-fault carrier.
  - 22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.
  - 23 = Claim adjusted because charges have been paid by another payer.
  - 24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
  - 25 = Payment denied. Your Stop loss deductible has not been met.
  - 26 = Expenses incurred prior to coverage.
  - 27 = Expenses incurred after coverage terminated.
  - 28 = Coverage not in effect at the time the service was provided.
  - 29 = The time limit for filing has expired.
  - 30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
  - 31 = Claim denied as patient cannot be identified as our insured.
  - 32 = Our records indicate that this dependent is not an eligible dependent as defined.
  - 33 = Claim denied. Insured has no dependent coverage.
  - 34 = Claim denied. Insured has no coverage for newborns.
  - 35 = Benefit maximum has been reached.
  - 36 = Balance does not exceed copayment amount.
  - 37 = Balance does not exceed deductible amount.

- 38 = Services not provided or authorized by designated (network) providers.

39 = Services denied at the time authorization/pre-certification was requested.

40 = Charges do not meet qualifications for emergency/urgent care.

41 = Discount agreed to in Preferred Provider contract.

42 = Charges exceed our fee schedule or maximum allowable amount.

43 = Gramm-Rudman reduction.

44 = Prompt-pay discount.

45 = Charges exceed your contracted/legislated fee arrangement.

46 = This (these) service(s) is(are) not covered.

47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.

48 = This (these) procedure(s) is(are) not covered.

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.

50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- Revenue Center ANSI Code Table  
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- 51 = These are non-covered services because this a pre-existing condition.

52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.

53 = Services by an immediate relative or a member of the same household are not covered.

54 = Multiple physicians/assistants are not covered in this case.

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.

60 = Charges for outpatient services with the proximity to inpatient services are not covered.

61 = Charges adjusted as penalty for failure to obtain second surgical opinion.

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible.

67 = Lifetime reserve days. INACTIVE  
68 = DRG weight. INACTIVE  
69 = Day outlier amount.  
70 = Cost outlier amount.  
71 = Primary Payer amount.  
72 = Coinsurance day. INACTIVE  
73 = Administrative days. INACTIVE  
74 = Indirect Medical Education Adjustment.  
75 = Direct Medical Education Adjustment.  
76 = Disproportionate Share Adjustment.  
77 = Covered days. INACTIVE  
78 = Non-covered days/room charge adjustment.  
79 = Cost report days. INACTIVE  
80 = Outlier days. INACTIVE  
81 = Discharges. INACTIVE  
82 = PIP days. INACTIVE  
83 = Total visits. INACTIVE  
84 = Capital adjustments. INACTIVE  
85 = Interest amount. INACTIVE  
86 = Statutory adjustment. INACTIVE  
87 = Transfer amounts.  
88 = Adjustment amount represents collection against  
    receivable created in prior overpayment.  
89 = Professional fees removed from charges.  
90 = Ingredient cost adjustment.

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REV\_CNTR\_ANSI\_TB  
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Revenue Center ANSI Code Table  
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91 = Dispensing fee adjustment.  
92 = Claim paid in full. INACTIVE  
93 = No claim level adjustment. INACTIVE  
94 = Process in excess of charges.  
95 = Benefits adjusted. Plan procedures not followed.  
96 = Non-covered charges.  
97 = Payment is included in allowance for another  
    service/procedure.  
98 = The hospital must file the Medicare claim for this  
    inpatient non-physician service. INACTIVE  
99 = Medicare Secondary Payer Adjustment Amount. INACTIVE  
100 = Payment made to patient/insured/responsible party.  
101 = Predetermination: anticipated payment upon comple-  
    tion of services or claim adjudication.  
102 = Major medical adjustment.  
103 = Provider promotional discount (i.e. Senior citizen  
    discount).  
104 = Managed care withholding.  
105 = Tax withholding.  
106 = Patient payment option/election not in effect.  
107 = Claim/service denied because the related or qualifying  
    claim/service was not paid or identified on the claim.  
108 = Claim/service reduced because rent/purchase guidelines  
    were not met.  
109 = Claim not covered by this payer/contractor. You must  
    send the claim to the correct payer/contractor.  
110 = Billing date predates service date.  
111 = Not covered unless the provider accepts assignment.  
112 = Claim/service adjusted as not furnished directly  
    to the patient and/or not documented.

- 113 = Claim denied because service/procedure was provided outside the United States or as a result of war.
  - 114 = Procedure/product not approved by the Food and Drug Administration.
  - 115 = Claim/service adjusted as procedure postponed or canceled.
  - 116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.
  - 117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.
  - 118 = Charges reduced for ESRD network support.
  - 119 = Benefit maximum for this time period has been reached.
  - 120 = Patient is covered by a managed care plan. INACTIVE
  - 121 = Indemnification adjustment.
  - 122 = Psychiatric reduction.
  - 123 = Payer refund due to overpayment. INACTIVE
  - 124 = Payer refund amount - not our patient. INACTIVE
  - 125 = Claim/service adjusted due to a submission/billing error(s).
  - 126 = Deductible - Major Medical.
  - 127 = Coinsurance - Major Medical.
  - 128 = Newborn's services are covered in the mother's allowance.
  - 129 = Claim denied - prior processing information appears incorrect.
  - 130 = Paper claim submission fee.
- Revenue Center ANSI Code Table  
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- 131 = Claim specific negotiated discount.
  - 132 = Prearranged demonstration project adjustment.
  - 133 = The disposition of this claim/service is pending further review.
  - 134 = Technical fees removed from charges.
  - 135 = Claim denied. Interim bills cannot be processed.
  - 136 = Claim adjusted. Plan procedures of a prior payer were not followed.
  - 137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
  - 138 = Claim/service denied. Appeal procedures not followed or time limits not met.
  - 139 = Contracted funding agreement - subscriber is employed by the provider of services.
  - 140 = Patient/Insured health identification number and name do not match.
  - 141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.
  - 142 = Claim adjusted by the monthly Medicaid patient liability amount.
  - A0 = Patient refund amount
  - A1 = Claim denied charges.
  - A2 = Contractual adjustment.
  - A3 = Medicare Secondary Payer liability met. INACTIVE
  - A4 = Medicare Claim PPS Capital Day Outlier Amount.
  - A5 = Medicare Claim PPS Capital Cost Outlier Amount.
  - A6 = Prior hospitalization or 30 day transfer requirement

not met.  
A7 = Presumptive Payment Adjustment.  
A8 = Claim denied; ungroupable DRG.  
B1 = Non-covered visits.  
B2 = Covered visits. INACTIVE  
B3 = Covered charges. INACTIVE  
B4 = Late filing penalty.  
B5 = Claim/service adjusted because coverage/program  
guidelines were not met or were exceeded.  
B6 = This service/procedure is adjusted when performed/  
billed by this type of provider, by this type of  
facility, or by a provider of this specialty.  
B7 = This provider was not certified/eligible to be  
paid for this procedure/service on this date of  
service.  
B8 = Claim/service not covered/reduced because alter-  
native services were available, and should have  
been utilized.  
B9 = Services not covered because the patient is en-  
rolled in a Hospice.  
B10 = Allowed amount has been reduced because a com-  
ponent of the basic procedure/test was paid. The  
beneficiary is not liable for more than the charge  
limit for the basic procedure/test.  
B11 = The claim/service has been transferred to the  
proper payer/processor for processing. Claim/  
service not covered by this payer/processor.  
B12 = Services not documented in patients' medical re-  
cords.  
B13 = Previously paid. Payment for this claim/service  
may have been provided in a previous payment.

Revenue Center ANSI Code Table

B14 = Claim/service denied because only one visit or  
consultation per physician per day is covered.  
B15 = Claim/service adjusted because this procedure/  
service is not paid separately.  
B16 = Claim/service adjusted because 'New Patient'  
qualifications were not met.  
B17 = Claim/service adjusted because this service was  
not prescribed by a physician, not prescribed  
prior to delivery, the prescription is incomplete,  
or the prescription is not current.  
B18 = Claim/service denied because this procedure code/  
modifier was invalid on the date of service or  
claim submission.  
B19 = Claim/service adjusted because of the finding of a  
Review Organization. INACTIVE  
B20 = Charges adjusted because procedure/service was  
partially or fully furnished by another provider.  
B21 = The charges were reduced because the service/care  
was partially furnished by another physician.  
INACTIVE  
B22 = This claim/service is adjusted based on the  
diagnosis.  
B23 = Claim/service denied because this provider has  
failed an aspect of a proficiency testing program.

W1 = Workers Compensation State Fee Schedule Adjustment.

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REV\_CNTR\_APC\_TB  
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Revenue Center Ambulatory Payment Classification (APC)  
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- 0001 = Photochemotherapy
- 0002 = Fine needle Biopsy/Aspiration
- 0003 = Bone Marrow Biopsy/Aspiration
- 0004 = Level I Needle Biopsy/ Aspiration Except  
Bone Marrow
- 0005 = Level II Needle Biopsy /Aspiration Except  
Bone Marrow
- 0006 = Level I Incision & Drainage
- 0007 = Level II Incision & Drainage
- 0008 = Level III Incision & Drainage
- 0009 = Nail Procedures
- 0010 = Level I Destruction of Lesion
- 0011 = Level II Destruction of Lesion
- 0012 = Level I Debridement & Destruction
- 0013 = Level II Debridement & Destruction
- 0014 = Level III Debridement & Destruction
- 0015 = Level IV Debridement & Destruction
- 0016 = Level V Debridement & Destruction
- 0017 = Level VI Debridement & Destruction
- 0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane
- 0019 = Level I Excision/ Biopsy
- 0020 = Level II Excision/ Biopsy
- 0021 = Level III Excision/ Biopsy
- 0022 = Level IV Excision/ Biopsy
- 0023 = Exploration Penetrating Wound
- 0024 = Level I Skin Repair
- 0025 = Level II Skin Repair
- 0026 = Level III Skin Repair
- 0027 = Level IV Skin Repair
- 0029 = Incision/Excision Breast
- 0030 = Breast Reconstruction/Mastectomy
- 0031 = Hyperbaric Oxygen
- 0032 = Placement Transvenous Catheters/Arterial Cutdown
- 0033 = Partial Hospitalization
- 0040 = Arthrocentesis & Ligament/Tendon Injection
- 0041 = Arthroscopy
- 0042 = Arthroscopically-Aided Procedures
- 0043 = Closed Treatment Fracture Finger/Toe/Trunk
- 0044 = Closed Treatment Fracture/Dislocation Except  
Finger/Toe/Trunk
- 0045 = Bone/Joint Manipulation Under Anesthesia
- 0046 = Open/Percutaneous Treatment Fracture or Dislocation
- 0047 = Arthroplasty without Prosthesis
- 0048 = Arthroplasty with Prosthesis
- 0049 = Level I Musculoskeletal Procedures Except Hand  
and Foot
- 0050 = Level II Musculoskeletal Procedures Except Hand  
and Foot
- 0051 = Level III Musculoskeletal Procedures Except Hand  
and Foot
- 0052 = Level IV Musculoskeletal Procedures Except Hand  
and Foot

- 0053 = Level I Hand Musculoskeletal Procedures
  - 0054 = Level II Hand Musculoskeletal Procedures
  - 0055 = Level I Foot Musculoskeletal Procedures
  - 0056 = Level II Foot Musculoskeletal Procedures
  - 0057 = Bunion Procedures
- Revenue Center Ambulatory Payment Classification (APC)  
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- 0058 = Level I Strapping and Cast Application
  - 0059 = Level II Strapping and Cast Application
  - 0060 = Manipulation Therapy
  - 0070 = Thoracentesis/Lavage Procedures
  - 0071 = Level I Endoscopy Upper Airway
  - 0072 = Level II Endoscopy Upper Airway
  - 0073 = Level III Endoscopy Upper Airway
  - 0074 = Level IV Endoscopy Upper Airway
  - 0075 = Level V Endoscopy Upper Airway
  - 0076 = Endoscopy Lower Airway
  - 0077 = Level I Pulmonary Treatment
  - 0078 = Level II Pulmonary Treatment
  - 0079 = Ventilation Initiation and Management
  - 0080 = Diagnostic Cardiac Catheterization
  - 0081 = Non-Coronary Angioplasty or Atherectomy
  - 0082 = Coronary Atherectomy
  - 0083 = Coronary Angiosplasty
  - 0084 = Level I Electrophysiologic Evaluation
  - 0085 = Level II Electrophysiologic Evaluation
  - 0086 = Ablate Heart Dysrhythm Focus
  - 0087 = Cardiac Electrophysiologic Recording/Mapping
  - 0088 = Thrombectomy
  - 0089 = Level I Implantation/Removal/Revision of Pacemaker,  
AICD Vascular Device
  - 0090 = Level II Implantation/Removal/Revision of Pacemaker,  
AICD Vascular Device
  - 0091 = Level I Vascular Ligation
  - 0092 = Level II Vascular Ligation
  - 0093 = Vascular Repair/Fistula Construction
  - 0094 = Resuscitation and Cardioversion
  - 0095 = Cardiac Rehabilitation
  - 0096 = Non-Invasive Vascular Studies
  - 0097 = Cardiovascular Stress Test
  - 0098 = Injection of Sclerosing Solution
  - 0099 = Continuous Cardiac Monitoring
  - 0100 = Continuous ECG
  - 0101 = Tilt Table Evaluation
  - 0102 = Electronic Analysis of Pacemakers/other Devices
  - 0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell  
Transplant
  - 0110 = Transfusion
  - 0111 = Blood Product Exchange
  - 0112 = Extracorporeal Photopheresis
  - 0113 = Excision Lymphatic System
  - 0114 = Thyroid/Lymphadenectomy Procedures
  - 0116 = Chemotherapy Administration by Other Technique  
Except Infusion
  - 0117 = Chemotherapy Administration by Infusion Only
  - 0118 = Chemotherapy Administration by Both Infusion and  
Other Technique

- 0120 = Infusion Therapy Except Chemotherapy
- 0121 = Level I Tube changes and Repositioning
- 0122 = Level II Tube changes and Repositioning
- 0123 = Level III Tube changes and Repositioning
- 0130 = Level I Laparoscopy
- 0131 = Level II Laparoscopy
- 0132 = Level III Laparoscopy
- 0140 = Esophageal Dilation without Endoscopy
- Revenue Center Ambulatory Payment Classification (APC)
- 
- 0141 = Upper GI Procedures
- 0142 = Small Intestine Endoscopy
- 0143 = Lower GI Endoscopy
- 0144 = Diagnostic Anoscopy
- 0145 = Therapeutic Anoscopy
- 0146 = Level I Sigmoidoscopy
- 0147 = Level II Sigmoidoscopy
- 0148 = Level I Anal/Rectal Procedure
- 0149 = Level II Anal/Rectal Procedure
- 0150 = Level III Anal/Rectal Procedure
- 0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
- 0152 = Percutaneous Biliary Endoscopic Procedures
- 0153 = Peritoneal and Abdominal Procedures
- 0154 = Hernia/Hydrocele Procedures
- 0157 = Colorectal Cancer Screening: Barium Enema  
(Not subject to National coinsurance)
- 0158 = Colorectal Cancer Screening: Colonoscopy  
Not subject to National coinsurance. Minimum  
unadjusted coinsurance is 25% of the payment rate.  
Payment rate is lower of the HOPD payment rate or  
the Ambulatory Surgical Center payment.
- 0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy  
Not subject to National coinsurance. Minimum  
unadjusted coinsurance is 25% of the payment rate.  
Payment rate is lower of the HOPD payment rate or  
the Ambulatory Surgical Center payment.
- 0160 = Level I Cystourethroscopy and other Genitourinary  
Procedures
- 0161 = Level II Cystourethroscopy and other Genitourinary  
Procedures
- 0162 = Level III Cystourethroscopy and other Genitourinary  
Procedures
- 0163 = Level IV Cystourethroscopy and other Genitourinary  
Procedures
- 0164 = Level I Urinary and Anal Procedures
- 0165 = Level II Urinary and Anal Procedures
- 0166 = Level I Urethral Procedures
- 0167 = Level II Urethral Procedures
- 0168 = Level III Urethral Procedures
- 0169 = Lithotripsy
- 0170 = Dialysis for Other Than ESRD Patients
- 0180 = Circumcision
- 0181 = Penile Procedures
- 0182 = Insertion of Penile Prosthesis
- 0183 = Testes/Epididymis Procedures
- 0184 = Prostate Biopsy
- 0190 = Surgical Hysteroscopy

0191 = Level I Female Reproductive Procedures  
0192 = Level II Female Reproductive Procedures  
0193 = Level III Female Reproductive Procedures  
0194 = Level IV Female Reproductive Procedures  
0195 = Level V Female Reproductive Procedures  
0196 = Dilatation & Curettage  
0197 = Infertility Procedures  
0198 = Pregnancy and Neonatal Care Procedures  
0199 = Vaginal Delivery  
0200 = Therapeutic Abortion  
0201 = Spontaneous Abortion  
Revenue Center Ambulatory Payment Classification (APC)  
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0210 = Spinal Tap  
0211 = Level I Nervous System Injections  
0212 = Level II Nervous System Injections  
0213 = Extended EEG Studies and Sleep Studies  
0214 = Electroencephalogram  
0215 = Level I Nerve and Muscle Tests  
0216 = Level II Nerve and Muscle Tests  
0217 = Level III Nerve and Muscle Tests  
0220 = Level I Nerve Procedures  
0221 = Level II Nerve Procedures  
0222 = Implantation of Neurological Device  
0223 = Level I Revision/Removal Neurological Device  
0224 = Level II Revision/Removal Neurological Device  
0225 = Implantation of Neurostimulator Electrodes  
0230 = Level I Eye Tests  
0231 = Level II Eye Tests  
0232 = Level I Anterior Segment Eye  
0233 = Level II Anterior Segment Eye  
0234 = Level III Anterior Segment Eye Procedures  
0235 = Level I Posterior Segment Eye Procedures  
0236 = Level II Posterior Segment Eye Procedures  
0237 = Level III Posterior Segment Eye Procedures  
0238 = Level I Repair and Plastic Eye Procedures  
0239 = Level II Repair and Plastic Eye Procedures  
0240 = Level III Repair and Plastic Eye Procedures  
0241 = Level IV Repair and Plastic Eye Procedures  
0242 = Level V Repair and Plastic Eye Procedures  
0243 = Strabismus/Muscle Procedures  
0244 = Corneal Transplant  
0245 = Cataract Procedures without IOL Insert  
0246 = Cataract Procedures with IOL Insert  
0247 = Laser Eye Procedures Except Retinal  
0248 = Laser Retinal Procedures  
0250 = Nasal Cauterization/Packing  
0251 = Level I ENT Procedures  
0252 = Level II ENT Procedures  
0253 = Level III ENT Procedures  
0254 = Level IV ENT Procedures  
0256 = Level V ENT Procedures  
0257 = Implantation of Cochlear Device  
0258 = Tonsil and Adenoid Procedures  
0260 = Level I Plain Film Except Teeth  
0261 = Level II Plain Film Except Teeth Including Bone  
Density Measurement

0262	= Plain Film of Teeth
0263	= Level I Miscellaneous Radiology Procedures
0264	= Level II Miscellaneous Radiology Procedures
0265	= Level I Diagnostic Ultrasound Except Vascular
0266	= Level II Diagnostic Ultrasound Except Vascular
0267	= Vascular Ultrasound
0268	= Guidance Under Ultrasound
0269	= Echocardiogram Except Transesophageal
0270	= Transesophageal Echocardiogram
0271	= Mammography
0272	= Level I Fluoroscopy
0273	= Level II Fluoroscopy
0274	= Myelography
0275	= Arthrography
	Revenue Center Ambulatory Payment Classification (APC)
	-----
0276	= Level I Digestive Radiology
0277	= Level II Digestive Radiology
0278	= Diagnostic Urography
0279	= Level I Diagnostic Angiography and Venography Except Extremity
0280	= Level II Diagnostic Angiography and Venography Except Extremity
0281	= Venography of Extremity
0282	= Level I Computerized Axial Tomography
0283	= Level II Computerized Axial Tomography
0284	= Magnetic Resonance Imaging
0285	= Positron Emission Tomography (PET)
0286	= Myocardial Scans
0290	= Standard Non-Imaging Nuclear Medicine
0291	= Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans
0292	= Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans
0294	= Level I Therapeutic Nuclear Medicine
0295	= Level II Therapeutic Nuclear Medicine
0296	= Level I Therapeutic Radiologic Procedures
0297	= Level II Therapeutic Radiologic Procedures
0300	= Level I Radiation Therapy
0301	= Level II Radiation Therapy
0302	= Level III Radiation Therapy
0303	= Treatment Device Construction
0304	= Level I Therapeutic Radiation Treatment Preparation
0305	= Level II Therapeutic Radiation Treatment Preparation
0310	= Level III Therapeutic Radiation Treatment Preparation
0311	= Radiation Physics Services
0312	= Radioelement Applications
0313	= Brachytherapy
0314	= Hyperthermic Therapies
0320	= Electroconvulsive Therapy
0321	= Biofeedback and Other Training
0322	= Brief Individual Psychotherapy
0323	= Extended Individual Psychotherapy
0324	= Family Psychotherapy

- 0325 = Group Psychotherapy
- 0330 = Dental Procedures
- 0340 = Minor Ancillary Procedures
- 0341 = Immunology Tests
- 0342 = Level I Pathology
- 0343 = Level II Pathology
- 0344 = Level III Pathology
- 0354 = Administration of Influenza Vaccine (Not subject to national coinsurance)
- 0355 = Level I Immunizations
- 0356 = Level II Immunizations
- 0357 = Level III Immunizations
- 0358 = Level IV Immunizations
- 0359 = Injections
- 0360 = Level I Alimentary Tests
- 0361 = Level II Alimentary Tests
- 0362 = Fitting of Vision Aids
- Revenue Center Ambulatory Payment Classification (APC)
- 
- 0363 = Otorhinolaryngologic Function Tests
- 0364 = Level I Audiometry
- 0365 = Level II Audiometry
- 0366 = Electrocardiogram (ECG)
- 0367 = Level I Pulmonary Test
- 0368 = Level II Pulmonary Test
- 0369 = Level III Pulmonary Test
- 0370 = Allergy Tests
- 0371 = Allergy Injections
- 0372 = Therapeutic Phlebotomy
- 0373 = Neuropsychological Testing
- 0374 = Monitoring Psychiatric Drugs
- 0600 = Low Level Clinic Visits
- 0601 = Mid Level Clinic Visits
- 0602 = High Level Clinic Visits
- 0603 = Interdisciplinary Team Conference
- 0610 = Low Level Emergency Visits
- 0611 = Mid Level Emergency Visits
- 0612 = High Level Emergency Visits
- 0620 = Critical Care
- 0701 = Strontium (eligible for pass-through payments)
- 0702 = Samarium (eligible for pass-through payments)
- 0704 = Sunitinib (eligible for pass-through payments)
- 0705 = Tc99 Tetrofosmin (eligible for pass-through payments)
- 0725 = Leucovorin Calcium (eligible for pass-through payments)
- 0726 = Dexrazoxane Hydrochloride (eligible for pass-through payments)
- 0727 = Injection, Etidronate Disodium (eligible for pass-through payments)
- 0728 = Filgrastim (G-CSF) (eligible for pass-through payments)
- 0730 = Pamidronate Disodium (eligible for pass-through payments)
- 0731 = Sargramostim (GM-CSF) (eligible for pass-through payments)

0732 = Mesna (eligible for pass-through payments)  
0733 = Epoetin Alpha (eligible for pass-through payments)  
0750 = Dolasetron Mesylate 10 mg (eligible for pass-through payments)  
0754 = Metoclopramide HCL (eligible for pass-through payments)  
0755 = Thiethylperazine Maleate (eligible for pass-through payments)  
0761 = Oral Substitute for IV Antiemtic (eligible for pass-through payments)  
0762 = Dronabinol (elible for pass-through payments)  
0763 = Dolasetron Mesylate 100 mg Oral (eligible for pass-through payments)  
0764 = Granisetron HCL, 100 mcg (eligible for pass-through payments)  
0765 = Granisetron HCL, 1mg Oral (eligible for pass-through payments)  
0768 = Ondansetron Hydrochloride per 1 mg Injection (eligible for pass-through payments)  
Revenue Center Ambulatory Payment Classification (APC)  
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0769 = Ondansetron Hydrochloride 8 mg oral (eligible for pass-through payments)  
0800 = Leuprolide Acetate per 3.75 mg (eligible for pass-through payments)  
0801 = Cyclophosphamide (eligible for pass-through payments)  
0802 = Etoposide (eligible for pass-through payments)  
0803 = Melphalan (eligible for pass-through payments)  
0807 = Aldesleukin single use vial (eligible for pass-through payments)  
0809 = BCG (Intravesical) one vial (eligible for pass-through payments)  
0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for pass-through payments)  
0811 = Carboplatin 50 mg (eligible for pass-through payments)  
0812 = Carmustine 100 mg (eligible for pass-through payments)  
0813 = Cisplatin 10 mg (eligible for pass-through payments)  
0814 = Asparaginase, 10,000 units (eligible for pass-through payments)  
0815 = Cyclophosphamide 100 mg (eligible for pass-through payments)  
0816 = Cyclophosphamide, Lyophilized 100 mg (eligible for pass-through payments)  
0817 = Cytrabine 100 mg (eligible for pass-through payments)  
0818 = Dactinomycin 0.5 mg (eligible for pass-through payments)  
0819 = Dacarbazine 100 mg (eligible for pass-through payments)  
0820 = Daunorubicin HCI 10 mg (eligible for pass-through payments)  
0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg

(eligible for pass-through payments)  
0822 = Diethylstilbestrol Diphosphate 250 mg  
(eligible for pass-through payments)  
0823 = Docetaxel 20 mg (eligible for pass-through  
payments)  
0824 = Etoposide 10 mg (eligible for pass-through  
payments)  
0826 = Methotrexate Oral 2.5 mg (eligible for pass-through  
payments)  
0827 = Floxuridine 500 mg (eligible for pass-through  
payments)  
0828 = Gemcitabine HCL 200 mg (eligibile for pass-  
through payments)  
0830 = Irinotecan 20 mg (eligible for pass-through  
payments)  
0831 = Ifosfamide per 1 gram (eligible for pass-through  
payments)  
0832 = Idarubicin Hydrochloride 5 mg (eligible for pass-  
through payments)  
0833 = Interferon Alfacon-1, Recombinant, 1 mcg  
(eligible for pass-through payments)  
0834 = Interferon, Alfa-2A, Recombinant 3 million units  
(eligible for pass-through payments)  
Revenue Center Ambulatory Payment Classification (APC)  
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0836 = Interferon, Alfa-2B, Recombinant, 1 million units  
(eligible for pass-through payments)  
0838 = Interferon, Gamma 1-B, 3 million units  
(eligible for pass-through payments)  
0839 = Mechlorethamine HCI 10 mg  
(eligible for pass-through payments)  
0840 = Melphalan HCI 50 mg (eligible for pass-  
through payments)  
0841 = Methotrexate Sodium 5 mg (eligible for pass-  
through payments)  
0842 = Fludarabine Phosphate 50 mg (eligible for pass-  
through payments)  
0843 = Pegaspargase per single dose vial (eligible for  
pass-through payments)  
0844 = Pentostatin 10 mg (eligible for pass-through  
payments)  
0847 = Doxorubicin HCL 10 mg (eligible for pass-through  
payments)  
0849 = Rituximab, 100 mg (eligible for pass-through  
payments)  
0850 = Streptozocin 1 gm (eligible for pass-through  
payments)  
0851 = Thiotepa 15 mg (eligible for pass-through pay-  
ments)  
0852 = Topotecan 4 mg (eligible for pass-through payments)  
0853 = Vinblastine Sulfate 1 mg (eligible for pass-through  
payments)  
0854 = Vincristine Sulfate 1 mg (eligible for pass-through  
payments)  
0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-  
through payments)  
0856 = Porfimer Sodium 75 mg (eligible for pass-through

payments)  
0857 = Bleomycin Sulfate 15 units (eligible for pass-through payments)  
0858 = Cladribine, 1mg (eligible for pass-through payments)  
0859 = Fluorouracil (eligible for pass-through payments)  
0860 = Plicamycin 2.5 mg (eligible for pass-through payments)  
0861 = Leuprolide Acetate 1 mg (eligible for pass-through payments)  
0862 = Mitomycin, 5mg (eligible for pass-through payments)  
0863 = Paclitaxel, 30mg (eligible for pass-through payments)  
0864 = Mitoxantrone HCl, per 5mg (eligible for pass-through payments)  
0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-through payments)  
0884 = Rho (D) Immune Globulin, Human one dose pack (eligible for pass-through payments)  
0886 = Azathioprine, 50 mg oral (Not subject to national coinsurance)  
0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection (Not subject to national coinsurance)  
0888 = Cyclosporine, Oral 100 mg (Not subject to national coinsurance)  
0889 = Cyclosporine, Parenteral (Not subject to national coinsurance)  
0890 = Lymphocyte Immune Globulin 50 mg/ ml, 5 ml each (Not subject to national coinsurance)  
Revenue Center Ambulatory Payment Classification (APC)  
-----  
0891 = Tacrolimus per 1 mg oral (Not subject to national coinsurance)  
0892 = Daclizumab, Parenteral, 25 mg (eligible for pass-through payments)  
0900 = Injection, Alglucerase per 10 units (eligible for pass-through payments)  
0901 = Alpha I, Proteinase Inhibitor, Human per 10mg (eligible for pass-through payments)  
0902 = Botulinum Toxin, Type A per unit (eligible for pass-through payments)  
0903 = CMV Immune Globulin (eligible for pass-through payments)  
0905 = Immune Globulin per 500 mg (eligible for pass-through payments)  
0906 = RSV Immune Globulin (eligible for pass-through payments)  
0907 = Ganciclovir Sodium 500 mg injection (Not subject to national coinsurance)  
0908 = Tetanus Immune Globulin, Human, up to 250 units (Not subject to national coinsurance)  
0909 = Interferon Beta - 1a 33 mcg (eligible for pass-through payments)  
0910 = Interferon Beta - 1b 0.25 mg (eligible for pass-through payments)  
0911 = Streptokinase per 250,000 iu (Not subject to national coinsurance)  
0913 = Ganciclovir 4.5 mg, Implant (eligible for pass-through payments)  
0914 = Reteplase, 37.6 mg (Two Single Use Vials)

- (Not subject to national coinsurance)

0915 = Alteplase recombinant, 10mg

(Not subject to national coinsurance)

0916 = Imiglucerase per unit (eligible for pass-through payments)

0917 = Dipyridamole, 10mg / Adenosine 6MG

(Not subject to national coinsurance)

0918 = Brachytherapy Seeds, Any type, Each (eligible for pass-through payments)

0925 = Factor VIII (Antihemophilic Factor, Human) per iu (eligible for pass-through payments)

0926 = Factor VIII (Antihemophilic Factor, Porcine) per iu (eligible for pass-through payments)

0927 = Factor VIII (Antihemophilic Factor, Recombinant) per iu (eligible for pass-through payments)

0928 = Factor IX, Complex (eligible for pass-through payments)

0929 = Other Hemophilia Clotting Factors per iu (eligible for pass-through payments)

0930 = Antithrombin III (Human) per iu (eligible for pass-through payments)

0931 = Factor IX (Antihemophilic Factor, Purified, Non-Recombinant) (eligible for pass-through payments)

0932 = Factor IX (Antihemophilic Factor, Recombinant) (eligible for pass-through payments)

0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen (not subject to national coinsurance)

0950 = Blood (Whole) For Transfusion (not subject to national coinsurance)

Revenue Center Ambulatory Payment Classification (APC)

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- 0952 = Cryoprecipitate (not subject to national coinsurance)

0953 = Fibrinogen Unit (not subject to national coinsurance)

0954 = Leukocyte Poor Blood (not subject to national coinsurance)

0955 = Plasma, Fresh Frozen (not subject to national coinsurance)

0956 = Plasma Protein Fraction (not subject to national coinsurance)

0957 = Platelet Concentrate (not subject to national coinsurance)

0958 = Platelet Rich Plasma (not subject to national coinsurance)

0959 = Red Blood Cells (not subject to national coinsurance)

0960 = Washed Red Blood Cells (not subject to national coinsurance)

0961 = Infusion, Albumin (Human) 5%, 500 ml (not subject to national coinsurance)

0962 = Infusion, Albumin (Human) 25%, 50 ml (not subject to national coinsurance)

0970 = New Technology - Level I (\$0 - \$50) (not subject to national coinsurance)

0971 = New Technology - Level II (\$50 - \$100) (not subject to national coinsurance)

0972 = New Technology - Level III (\$100 - \$200) (not subject to national coinsurance)

0973 = New Technology - Level IV (\$200 - \$300)

(not subject to national coinsurance)  
0974 = New Technology - Level V (\$300 - \$500)  
(not subject to national coinsurance)  
0975 = New Technology - Level VI (\$500 - \$750)  
(not subject to national coinsurance)  
0976 = New Technology - Level VII (\$750 - \$1000)  
(not subject to national coinsurance)  
0977 = New Technology - Level VIII (\$1000 - \$1250)  
(not subject to national coinsurance)  
0978 = New Technology - Level IX (\$1250 - \$1500)  
(not subject to national coinsurance)  
0979 = New Technology - Level X (\$1500 - \$1750)  
(not subject to national coinsurance)  
0980 = New Technology - Level XI (\$1750 - \$2000)  
(not subject to national coinsurance)  
0981 = New Technology - Level XII (\$2000 - \$2500)  
(not subject to national coinsurance)  
0982 = New Technology - Level XIII (\$2500 - \$3500)  
(not subject to national coinsurance)  
0983 = New Technology - Level XIV (\$3500 - \$5000)  
(not subject to national coinsurance)  
0984 = New Technology - Level XV (\$5000 - \$6000)  
(not subject to national coinsurance)  
7000 = Amifostine, 500 mg (eligible for pass-through payments)  
7001 = Amphotericin B lipid complex, 50 mg, Inj  
(eligible for pass-through payments)  
7002 = Clonidine, HCl, 1 MG (eligible for pass-through payments)  
7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-through payments)  
7004 = Immune globulin intravenous human 5g, inj  
Revenue Center Ambulatory Payment Classification (APC)  
-----  
  
(eligible for pass-through payments)  
7005 = Gonadorelin hcl, 100 mcg (eligible for pass-through payments)  
7007 = Milrinone lactate, per 5 ml, inj (not subject to national coinsurance)  
7010 = Morphine sulfate concentrate (preservative free) per 10 mg (eligible for pass-through payments)  
7011 = Oprelevakin, inj, 5 mg (eligible for pass-through payments)  
7012 = Pentamidine isethionate, 300 mg (eligible for pass-through payments)  
7014 = Fentanyl citrate, inj, up to 2 ml (eligible for pass-through payments)  
7015 = Busulfan, oral 2 mg (eligible for pass-through payments)  
7019 = Aprotinin, 10,000 kiu (eligible for pass-through payments)  
7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-through payments)  
7022 = Elliotts B Solution, per ml (eligible for pass-through payments)  
7023 = Treatment for bladder calculi, I.e. Renacidin per 500 ml (eligible for pass-through payments)

1	REV_CNTR_APC_TB -----	7024 = Corticorelin ovine triflutate, 0.1 mg (eligible for pass-through payments)
		7025 = Digoxin immune FAB (Ovine), 10 mg (eligible for pass-through payments)
		7026 = Ethanolamine oleate, 1000 ml (eligible for pass-through payments)
		7027 = Fomepizole, 1.5 G (eligible for pass-through payments)
		7028 = Fosphenytoin, 50 mg (eligible for pass-through payments)
		7029 = Glatiramer acetate, 25 mg (eligible for pass-through payments)
		7030 = Hemin, 1 mg (eligible for pass-through payments)
		7031 = Octreotide Acetate, 500 mcg (eligible for pass-through payments)
		7032 = Sermorelin acetate, 0.5 mg (eligible for pass-through payments)
		7033 = Somatrem, 5 mg (eligible for pass-through payments)
		7034 = Somatropin, 1 mg (eligible for pass-through payments)
		7035 = Teniposide, 50 mg (eligible for pass-through payments)
		7036 = Urokinase, inj, IV, 250,000 I.U. (not subject to national coinsurance)
		7037 = Urofollitropin, 75 I.U. (eligible for pass-through payments)
		7038 = Muromonab-CD3, 5 mg (eligible for pass-through payments)
		7039 = Pegademase bovine inj 25 I.U. (eligible for pass-through payments)
		7040 = Pentastarch 10% inj, 100 ml (eligible for pass-through payments)
		7041 = Tirofiban HCL, 0.5 mg Revenue Center Ambulatory Payment Classification (APC) -----
		(not subject to national coinsurance)
		7042 = Capecitabine, oral 150 mg (eligible for pass-through payments)
		7043 = Infliximab, 10 MG (eligible for pass-through payments)
		7045 = Trimetrexate Glucoronate (eligible for pass- through payments)
		7046 = Doxorubicin Hcl Liposome (eligible for pass- through payments)
1	REV_CNTR_DDCTBL_COINSRNC_TB -----	Revenue Center Deductible Coinsurance Code -----
		0 = Charges are subject to deductible and coinsurance
		1 = Charges are not subject to deductible
		2 = Charges are not subject to coinsurance
		3 = Charges are not subject to deductible or coinsurance

4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

For revenue center code 0001, the following MSP override values may be present:

- M = Override code; EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
- N = Override code; non-EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
- X = Override code: MSP cost avoided (eff 12/90 for non-institutional claims; 10/93 for institutional claims)

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REV\_CNTR\_PMT\_MTHD\_IND\_TB

Revenue Center Payment Method Indicator Table

\*\*\*\*\*Service Indicator\*\*\*\*\*  
\*\*\*\*\* 1st position \*\*\*\*\*  
A = Services not paid under OPPS  
C = Inpatient procedure  
E = Noncovered items or services  
F = Corneal issue acquisition  
G = Current drug or biological pass-through  
H = Device pass-through  
J = New drug or new biological pass-through  
N = Packaged incidental service  
P = Partial hospitalization services  
S = Significant procedure not subject to multiple procedure discounting  
T = Significant procedure subject to multiple procedure discounting  
V = Medical visit to clinic or emergency department  
X = Ancillary service

\*\*\*\*\*Payment Indicator\*\*\*\*\*  
\*\*\*\*\* 2nd position \*\*\*\*\*  
1 = Paid standard hospital OPPS amount (service indicators S,T,V,X)  
2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes)  
3 = Not paid (service indicators C & E)  
4 = Acquisition cost paid (service indicator F)  
5 = Additional payment for current drug or biological (service indicator G)  
6 = Additional payment for device (service indicator H)  
7 = Additional payment for new drug or new biological (service indicator J)  
8 = Paid partial hospitalization per diem (service indicator P)

9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training))

1     REV\_CNTR\_PRICNG\_IND\_TB  
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Revenue Center Pricing Indicator Table  
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- A = A valid HCPCS code not subject to a fee schedule payment. Reimbursement is calculated on provider submitted charges.
- B = A valid HCPCS code subject to the fee schedule payment. Reimbursement is the lesser of provider submitted charges or the fee schedule amount.
- D = a valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treats this HCPCS as a non-covered service. Reimbursement is calculated on provider submitted charges.
- E = A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report.
- F = A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS.
- G = A valid HCPCS, code is subject to a fee schedule, but the rate is no longer present on the HCPCS file. Reimbursement is calculated on provider submitted charges.
- H = A valid DME HCPCS, code is subject to a fee schedule. The rates are reflected under the DME segment. Reimbursement is calculated either on a fee schedule, provider submitted charges or the lesser of provider submitted, or the fee schedule depending on the category.
- I = A valid DME category 5 HCPCS, HCPCS is not found on the DME history record, but a match was found on HIC, category and generic code. Claim must be reviewed by Medical Review before payment can be calculated.
- J = A valid DME HCPCS, no DME history is present, and a prescription is required before delivery. Claim must be reviewed by Medical Review.
- K = A valid DME HCPCS, prescribed has been reviewed, and fee schedule payment is approved as prescription was present before delivery.
- L = A valid TENS HCPCS, rental period is six months or greater and must be reviewed by Medical Review.
- M = A valid TENS HCPCS, Medical Review has approved the rental charge in excess of five months.
- R = A valid radiology HCPCS code and is subject to the Radiology Pricer. The rate is reported on the cost report. Reimbursement is calculated on provider

submitted charges.  
S = Valid influenza/PPV HCPCS. A fee amount is not applicable. The amount payable is present in the covered charge field. This amount is not subject to the coinsurance and deductible. This charge is subject to the provider's reimbursement rate.  
T = Valid HCPCS. A fee amount is present. The amount payable should be the lower of the billed charge or Revenue Center Pricing Indicator Table

1 REV\_CNTR\_PRICNG\_IND\_TB  
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fee amount. The system should compute the fee amount by multiplying the covered units times the rate. The fee amount is not subject to coinsurance and deductible or provider's reimbursement rate.

1 REV\_CNTR\_TB  
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Revenue Center Table  
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- 0001 = Total charge
- 0022 = SNF claim paid under PPS submitted as TOB 21X, effective for cost reporting periods beginning on or after 7/1/98 (dates of service after 6/30/98). NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.
- 0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).
- 0100 = All inclusive rate-room and board plus ancillary
- 0101 = All inclusive rate-room and board
- 0110 = Private medical or general-general classification
- 0111 = Private medical or general-medical/surgical/GYN
- 0112 = Private medical or general-OB
- 0113 = Private medical or general-pediatric
- 0114 = Private medical or general-psychiatric
- 0115 = Private medical or general-hospice
- 0116 = Private medical or general-detoxification
- 0117 = Private medical or general-oncology
- 0118 = Private medical or general-rehabilitation
- 0119 = Private medical or general-other
- 0120 = Semi-private 2 bed (medical or general) general classification
- 0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN
- 0122 = Semi-private 2 bed (medical or general)-OB
- 0123 = Semi-private 2 bed (medical or general)-pediatric
- 0124 = Semi-private 2 bed (medical or general)-psychiatric
- 0125 = Semi-private 2 bed (medical or general)-hospice
- 0126 = Semi-private 2 bed (medical or general) detoxification
- 0127 = Semi-private 2 bed (medical or general)-oncology
- 0128 = Semi-private 2 bed (medical or general) rehabilitation
- 0129 = Semi-private 2 bed (medical or general)-other
- 0130 = Semi-private 3 and 4 beds-general classification
- 0131 = Semi-private 3 and 4 beds-medical/surgical/GYN
- 0132 = Semi-private 3 and 4 beds-OB

- 0133 = Semi-private 3 and 4 beds-pediatric  
0134 = Semi-private 3 and 4 beds-psychiatric  
0135 = Semi-private 3 and 4 beds-hospice  
0136 = Semi-private 3 and 4 beds-detoxification  
0137 = Semi-private 3 and 4 beds-oncology  
0138 = Semi-private 3 and 4 beds-rehabilitation  
0139 = Semi-private 3 and 4 beds-other  
0140 = Private (deluxe)-general classification  
0141 = Private (deluxe)-medical/surgical/GYN  
0142 = Private (deluxe)-OB  
0143 = Private (deluxe)-pediatric  
0144 = Private (deluxe)-psychiatric  
0145 = Private (deluxe)-hospice  
0146 = Private (deluxe)-detoxification  
0147 = Private (deluxe)-oncology  
0148 = Private (deluxe)-rehabilitation  
0149 = Private (deluxe)-other
- Revenue Center Table  
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- 0150 = Room&Board ward (medical or general)  
general classification  
0151 = Room&Board ward (medical or general)  
medical/surgical/GYN  
0152 = Room&Board ward (medical or general)-OB  
0153 = Room&Board ward (medical or general)-pediatric  
0154 = Room&Board ward (medical or general)-psychiatric  
0155 = Room&Board ward (medical or general)-hospice  
0156 = Room&Board ward (medical or general)-detoxification  
0157 = Room&Board ward (medical or general)-oncology  
0158 = Room&Board ward (medical or general)-rehabilitation  
0159 = Room&Board ward (medical or general)-other  
0160 = Other Room&Board-general classification  
0164 = Other Room&Board-sterile environment  
0167 = Other Room&Board-self care  
0169 = Other Room&Board-other  
0170 = Nursery-general classification  
0171 = Nursery-newborn  
level I (routine)  
0172 = Nursery-premature  
newborn-level II (continuing care)  
0173 = Nursery-newborn-level III (intermediate care)  
(eff 10/96)  
0174 = Nursery-newborn-level IV (intensive care)  
(eff 10/96)  
0175 = Nursery-neonatal ICU (obsolete eff 10/96)  
0179 = Nursery-other  
0180 = Leave of absence-general classification  
0182 = Leave of absence-patient convenience charges  
billable  
0183 = Leave of absence-therapeutic leave  
0184 = Leave of absence-ICF mentally retarded-any reason  
0185 = Leave of absence-nursing home (hospitalization)  
0189 = Leave of absence-other leave of absence  
0190 = Subacute care - general classification  
(eff. 10/97)  
0191 = Subacute care - level I (eff. 10/97)  
0192 = Subacute care - level II (eff. 10/97)

- 0193 = Subacute care - level III (eff. 10/97)
  - 0194 = Subacute care - level IV (eff. 10/97)
  - 0199 = Subacute care - other (eff 10/97)
  - 0200 = Intensive care-general classification
  - 0201 = Intensive care-surgical
  - 0202 = Intensive care-medical
  - 0203 = Intensive care-pediatric
  - 0204 = Intensive care-psychiatric
  - 0206 = Intensive care-post ICU; redefined as  
intermediate ICU (eff 10/96)
  - 0207 = Intensive care-burn care
  - 0208 = Intensive care-trauma
  - 0209 = Intensive care-other intensive care
  - 0210 = Coronary care-general classification
  - 0211 = Coronary care-myocardial infraction
  - 0212 = Coronary care-pulmonary care
  - 0213 = Coronary care-heart transplant
  - 0214 = Coronary care-post CCU; redefined as  
intermediate CCU (eff 10/96)
  - 0219 = Coronary care-other coronary care
- Revenue Center Table  
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- 0220 = Special charges-general classification
  - 0221 = Special charges-admission charge
  - 0222 = Special charges-technical support charge
  - 0223 = Special charges-UR service charge
  - 0224 = Special charges-late discharge, medically  
necessary
  - 0229 = Special charges-other special charges
  - 0230 = Incremental nursing charge rate-general  
classification
  - 0231 = Incremental nursing charge rate-nursery
  - 0232 = Incremental nursing charge rate-OB
  - 0233 = Incremental nursing charge rate-ICU (include  
transitional care)
  - 0234 = Incremental nursing charge rate-CCU (include  
transitional care)
  - 0235 = Incremental nursing charge rate-hospice
  - 0239 = Incremental nursing charge rate-other
  - 0240 = All inclusive ancillary-general classification
  - 0241 = All inclusive ancillary-basic
  - 0242 = All inclusive ancillary-comprehensive
  - 0243 = All inclusive ancillary-specialty
  - 0249 = All inclusive ancillary-other inclusive ancillary
  - 0250 = Pharmacy-general classification
  - 0251 = Pharmacy-generic drugs
  - 0252 = Pharmacy-nongeneric drugs
  - 0253 = Pharmacy-take home drugs
  - 0254 = Pharmacy-drugs incident to other diagnostic service-  
subject to payment limit
  - 0255 = Pharmacy-drugs incident to radiology-  
subject to payment limit
  - 0256 = Pharmacy-experimental drugs
  - 0257 = Pharmacy-non-prescription
  - 0258 = Pharmacy-IV solutions
  - 0259 = Pharmacy-other pharmacy
  - 0260 = IV therapy-general classification

- 0261 = IV therapy-infusion pump
- 0262 = IV therapy-pharmacy services (eff 10/94)
- 0263 = IV therapy-drug supply/delivery (eff 10/94)
- 0264 = IV therapy-supplies (eff 10/94)
- 0269 = IV therapy-other IV therapy
- 0270 = Medical/surgical supplies-general classification  
(also see 062X)
- 0271 = Medical/surgical supplies-nonsterile supply
- 0272 = Medical/surgical supplies-sterile supply
- 0273 = Medical/surgical supplies-take home supplies
- 0274 = Medical/surgical supplies-prosthetic/orthotic  
devices
- 0275 = Medical/surgical supplies-pace maker
- 0276 = Medical/surgical supplies-intraocular lens
- 0277 = Medical/surgical supplies-oxygen-take home
- 0278 = Medical/surgical supplies-other implants
- 0279 = Medical/surgical supplies-other devices
- 0280 = Oncology-general classification
- 0289 = Oncology-other oncology
- 0290 = DME (other than renal)-general classification
- 0291 = DME (other than renal)-rental
- 0292 = DME (other than renal)-purchase of new DME
- 0293 = DME (other than renal)-purchase of used DME
- Revenue Center Table  
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- 0294 = DME (other than renal)-related to and listed as DME
- 0299 = DME (other than renal)-other
- 0300 = Laboratory-general classification
- 0301 = Laboratory-chemistry
- 0302 = Laboratory-immunology
- 0303 = Laboratory-renal patient (home)
- 0304 = Laboratory-non-routine dialysis
- 0305 = Laboratory-hematology
- 0306 = Laboratory-bacteriology & microbiology
- 0307 = Laboratory-urology
- 0309 = Laboratory-other laboratory
- 0310 = Laboratory pathological-general classification
- 0311 = Laboratory pathological-cytology
- 0312 = Laboratory pathological-histology
- 0314 = Laboratory pathological-biopsy
- 0319 = Laboratory pathological-other
- 0320 = Radiology diagnostic-general classification
- 0321 = Radiology diagnostic-angiocardiology
- 0322 = Radiology diagnostic-arthrography
- 0323 = Radiology diagnostic-arteriography
- 0324 = Radiology diagnostic-chest X-ray
- 0329 = Radiology diagnostic-other
- 0330 = Radiology therapeutic-general classification
- 0331 = Radiology therapeutic-chemotherapy injected
- 0332 = Radiology therapeutic-chemotherapy oral
- 0333 = Radiology therapeutic-radiation therapy
- 0335 = Radiology therapeutic-chemotherapy IV
- 0339 = Radiology therapeutic-other
- 0340 = Nuclear medicine-general classification
- 0341 = Nuclear medicine-diagnostic
- 0342 = Nuclear medicine-therapeutic
- 0349 = Nuclear medicine-other

0350 = Computed tomographic (CT) scan-general  
classification  
0351 = CT scan-head scan  
0352 = CT scan-body scan  
0359 = CT scan-other CT scans  
0360 = Operating room services-general classification  
0361 = Operating room services-minor surgery  
0362 = Operating room services-organ transplant,  
other than kidney  
0367 = Operating room services-kidney transplant  
0369 = Operating room services-other operating room  
services  
0370 = Anesthesia-general classification  
0371 = Anesthesia-incident to RAD and  
subject to the payment limit  
0372 = Anesthesia-incident to other diagnostic service  
and subject to the payment limit  
0374 = Anesthesia-acupuncture  
0379 = Anesthesia-other anesthesia  
0380 = Blood-general classification  
0381 = Blood-packed red cells  
0382 = Blood-whole blood  
0383 = Blood-plasma  
0384 = Blood-platelets  
0385 = Blood-leukocytes  
0386 = Blood-other components

Revenue Center Table  
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0387 = Blood-other derivatives (cryoprecipitates)  
0389 = Blood-other blood  
0390 = Blood storage and processing-general  
classification  
0391 = Blood storage and processing-blood  
administration  
0399 = Blood storage and processing-other  
0400 = Other imaging services-general classification  
0401 = Other imaging services-diagnostic mammography  
0402 = Other imaging services-ultrasound  
0403 = Other imaging services-screening mammography  
(eff 1/1/91)  
0404 = Other imaging services-positron emission  
tomography (eff 10/94)  
0409 = Other imaging services-other  
0410 = Respiratory services-general classification  
0412 = Respiratory services-inhalation services  
0413 = Respiratory services-hyperbaric oxygen therapy  
0419 = Respiratory services-other  
0420 = Physical therapy-general classification  
0421 = Physical therapy-visit charge  
0422 = Physical therapy-hourly charge  
0423 = Physical therapy-group rate  
0424 = Physical therapy-evaluation or re-evaluation  
0429 = Physical therapy-other  
0430 = Occupational therapy-general classification  
0431 = Occupational therapy-visit charge  
0432 = Occupational therapy-hourly charge  
0433 = Occupational therapy-group rate

0434 = Occupational therapy-evaluation or re-evaluation  
0439 = Occupational therapy-other (may include  
restorative therapy)  
0440 = Speech language pathology-general classification  
0441 = Speech language pathology-visit charge  
0442 = Speech language pathology-hourly charge  
0443 = Speech language pathology-group rate  
0444 = Speech language pathology-evaluation or  
re-evaluation  
0449 = Speech language pathology-other  
0450 = Emergency room-general classification  
0451 = Emergency room-emptala emergency medical screening  
services (eff 10/96)  
0452 = Emergency room-ER beyond emptala screening  
(eff 10/96)  
0456 = Emergency room-urgent care (eff 10/96)  
0459 = Emergency room-other  
0460 = Pulmonary function-general classification  
0469 = Pulmonary function-other  
0470 = Audiology-general classification  
0471 = Audiology-diagnostic  
0472 = Audiology-treatment  
0479 = Audiology-other  
0480 = Cardiology-general classification  
0481 = Cardiology-cardiac cath lab  
0482 = Cardiology-stress test  
0483 = Cardiology-Echocardiology  
0489 = Cardiology-other  
0490 = Ambulatory surgical care-general classification  
Revenue Center Table  
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0499 = Ambulatory surgical care-other  
0500 = Outpatient services-general classification  
(deleted 9/93)  
0509 = Outpatient services-other (deleted 9/93)  
0510 = Clinic-general classification  
0511 = Clinic-chronic pain center  
0512 = Clinic-dental center  
0513 = Clinic-psychiatric  
0514 = Clinic-OB-GYN  
0515 = Clinic-pediatric  
0516 = Clinic-urgent care clinic (eff 10/96)  
0517 = Clinic-family practice clinic (eff 10/96)  
0519 = Clinic-other  
0520 = Free-standing clinic-general classification  
0521 = Free-standing clinic-rural health clinic  
0522 = Free-standing clinic-rural health home  
0523 = Free-standing clinic-family practice  
0526 = Free-standing clinic-urgent care (eff 10/96)  
0529 = Free-standing clinic-other  
0530 = Osteopathic services-general classification  
0531 = Osteopathic services-osteopathic therapy  
0539 = Osteopathic services-other  
0540 = Ambulance-general classification  
0541 = Ambulance-supplies  
0542 = Ambulance-medical transport  
0543 = Ambulance-heart mobile

- 0544 = Ambulance-oxygen
  - 0545 = Ambulance-air ambulance
  - 0546 = Ambulance-neo-natal ambulance
  - 0547 = Ambulance-pharmacy
  - 0548 = Ambulance-telephone transmission EKG
  - 0549 = Ambulance-other
  - 0550 = Skilled nursing-general classification
  - 0551 = Skilled nursing-visit charge
  - 0552 = Skilled nursing-hourly charge
  - 0559 = Skilled nursing-other
  - 0560 = Medical social services-general classification
  - 0561 = Medical social services-visit charge
  - 0562 = Medical social services-hourly charges
  - 0569 = Medical social services-other
  - 0570 = Home health aid (home health)-general classification
  - 0571 = Home health aid (home health)-visit charge
  - 0572 = Home health aid (home health)-hourly charge
  - 0579 = Home health aid (home health)-other
  - 0580 = Other visits (home health)-general classification (under HHPPS, not allowed as covered charges)
  - 0581 = Other visits (home health)-visit charge (under HHPPS, not allowed as covered charges)
  - 0582 = Other visits (home health)-hourly charge (under HHPPS, not allowed as covered charges)
  - 0589 = Other visits (home health)-other (under HHPPS, not allowed as covered charges)
  - 0590 = Units of service (home health)-general classification (under HHPPS, not allowed as covered charges)
  - 0599 = Units of service (home health)-other
- Revenue Center Table  
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- (under HHPPS, not allowed as covered charges)
- 0600 = Oxygen-general classification
  - 0601 = Oxygen-stat or port equip/supply or count
  - 0602 = Oxygen-stat/equip/under 1 LPM
  - 0603 = Oxygen-stat/equip/over 4 LPM
  - 0604 = Oxygen-stat/equip/portable add-on
  - 0610 = Magnetic resonance technology (MRT)-general classification
  - 0611 = MRT/MRI-brain (including brainstem)
  - 0612 = MRT/MRI-spinal cord (including spine)
  - 0614 = MRT/MRI-other
  - 0615 = MRT/MRA-Head and Neck
  - 0616 = MRT/MRA-Lower Extremities
  - 0618 = MRT/MRA-other
  - 0619 = MRT/Other MRI
  - 0621 = Medical/surgical supplies-incident to radiology-subject to the payment limit - extension of 027X
  - 0622 = Medical/surgical supplies-incident to other diagnostic service-subject to the payment limit - extension of 027X
  - 0623 = Medical/surgical supplies-surgical dressings (eff 1/95) - extension of 027X
  - 0624 = Medical/surgical supplies-medical investigational

devices and procedures with FDA approved IDE's  
(eff 10/96) - extension of 027X  
0630 = Drugs requiring specific identification-general  
classification  
0631 = Drugs requiring specific identification-single drug  
source (eff 9/93)  
0632 = Drugs requiring specific identification-multiple drug  
source (eff 9/93)  
0633 = Drugs requiring specific identification-restrictive  
prescription (eff 9/93)  
0634 = Drugs requiring specific identification-EPO under  
10,000 units  
0635 = Drugs requiring specific identification-EPO 10,000  
units or more  
0636 = Drugs requiring specific identification-detailed  
coding (eff 3/92)  
0637 = Self-administered drugs administered in an  
emergency situation - not requiring detailed  
coding  
0640 = Home IV therapy-general classification  
(eff 10/94)  
0641 = Home IV therapy-nonroutine nursing  
(eff 10/94)  
0642 = Home IV therapy-IV site care, central line  
(eff 10/94)  
0643 = Home IV therapy-IV start/change peripheral line  
(eff 10/94)  
0644 = Home IV therapy-nonroutine nursing, peripheral line  
(eff 10/94)  
0645 = Home IV therapy-train patient/caregiver, central  
line (eff 10/94)  
0646 = Home IV therapy-train disabled patient, central  
line (eff 10/94)  
0647 = Home IV therapy-train patient/caregiver, peripheral  
line (eff 10/94)

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0648 = Home IV therapy-train disabled patient, peripheral  
line (eff 10/94)  
0649 = Home IV therapy-other IV therapy services  
(eff 10/94)  
0650 = Hospice services-general classification  
0651 = Hospice services-routine home care  
0652 = Hospice services-continuous home care-1/2  
0655 = Hospice services-inpatient care  
0656 = Hospice services-general inpatient care  
(non-respite)  
0657 = Hospice services-physician services  
0659 = Hospice services-other  
0660 = Respite care (HHA)-general classification  
(eff 9/93)  
0661 = Respite care (HHA)-hourly charge/skilled nursing  
(eff 9/93)  
0662 = Respite care (HHA)-hourly charge/home health aide/  
homemaker (eff 9/93)  
0670 = OP special residence charges - general  
classification

0671 = OP special residence charges - hospital based  
0672 = OP special residence charges - contracted  
0679 = OP special residence charges - other special  
residence charges  
0700 = Cast room-general classification  
0709 = Cast room-other  
0710 = Recovery room-general classification  
0719 = Recovery room-other  
0720 = Labor room/delivery-general classification  
0721 = Labor room/delivery-labor  
0722 = Labor room/delivery-delivery  
0723 = Labor room/delivery-circumcision  
0724 = Labor room/delivery-birthing center  
0729 = Labor room/delivery-other  
0730 = EKG/ECG-general classification  
0731 = EKG/ECG-Holter monitor  
0732 = EKG/ECG-telemetry (include fetal monitoring until  
9/93)  
0739 = EKG/ECG-other  
0740 = EEG-general classification  
0749 = EEG (electroencephalogram)-other  
0750 = Gastro-intestinal services-general classification  
0759 = Gastro-intestinal services-other  
0760 = Treatment or observation room-general  
classification  
0761 = Treatment or observation room-treatment room  
(eff 9/93)  
0762 = Treatment or observation room-observation room  
(eff 9/93)  
0769 = Treatment or observation room-other  
0770 = Preventative care services-general classification  
(eff 10/94)  
0771 = Preventative care services-vaccine administration  
(eff 10/94)  
0779 = Preventative care services-other (eff 10/94)  
0780 = Telemedicine - general classification  
(eff 10/97)  
0789 = Telemedicine - telemedicine (eff 10/97)  
Revenue Center Table  
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0790 = Lithotripsy-general classification  
0799 = Lithotripsy-other  
0800 = Inpatient renal dialysis-general classification  
0801 = Inpatient renal dialysis-inpatient hemodialysis  
0802 = Inpatient renal dialysis-inpatient peritoneal  
(non-CAPD)  
0803 = Inpatient renal dialysis-inpatient CAPD  
0804 = Inpatient renal dialysis-inpatient CCPD  
0809 = Inpatient renal dialysis-other inpatient dialysis  
0810 = Organ acquisition-general classification  
0811 = Organ acquisition-living donor (eff 10/94);  
prior to 10/94, defined as living donor kidney  
0812 = Organ acquisition-cadaver donor (eff 10/94);  
prior to 10/94, defined as cadaver donor kidney  
0813 = Organ acquisition-unknown donor (eff 10/94)  
prior to 10/94, defined as unknown donor kidney  
0814 = Organ acquisition - unsuccessful organ search-

donor bank charges (eff 10/94); prior to 10/94,  
 defined as other kidney acquisition  
 0815 = Organ acquisition-cadaver donor-heart  
 (obsolete, eff 10/94)  
 0816 = Organ acquisition-other heart acquisition  
 (obsolete, eff 10/94)  
 0817 = Organ acquisition-donor-liver  
 (obsolete, eff 10/94)  
 0819 = Organ acquisition-other donor (eff 10/94);  
 prior to 10/94, defined as other  
 0820 = Hemodialysis OP or home dialysis-general  
 classification  
 0821 = Hemodialysis OP or home dialysis-hemodialysis-  
 composite or other rate  
 0822 = Hemodialysis OP or home dialysis-home supplies  
 0823 = Hemodialysis OP or home dialysis-home equipment  
 0824 = Hemodialysis OP or home dialysis-maintenance/100%  
 0825 = Hemodialysis OP or home dialysis-support services  
 0829 = Hemodialysis OP or home dialysis-other  
 0830 = Peritoneal dialysis OP or home-general  
 classification  
 0831 = Peritoneal dialysis OP or home-peritoneal-  
 composite or other rate  
 0832 = Peritoneal dialysis OP or home-home supplies  
 0833 = Peritoneal dialysis OP or home-home equipment  
 0834 = Peritoneal dialysis OP or home-maintenance/100%  
 0835 = Peritoneal dialysis OP or home-support services  
 0839 = Peritoneal dialysis OP or home-other  
 0840 = CAPD outpatient-general classification  
 0841 = CAPD outpatient-CAPD/composite or other rate  
 0842 = CAPD outpatient-home supplies  
 0843 = CAPD outpatient-home equipment  
 0844 = CAPD outpatient-maintenance/100%  
 0845 = CAPD outpatient-support services  
 0849 = CAPD outpatient-other  
 0850 = CCPD outpatient-general classification  
 0851 = CCPD outpatient-CCPD/composite or other rate  
 0852 = CCPD outpatient-home supplies  
 0853 = CCPD outpatient-home equipment  
 0854 = CCPD outpatient-maintenance/100%  
 0855 = CCPD outpatient-support services  
 0859 = CCPD outpatient-other  
 0880 = Miscellaneous dialysis-general classification  
 0881 = Miscellaneous dialysis-ultrafiltration  
 0882 = Miscellaneous dialysis-home dialysis aide visit  
 (eff 9/93)  
 0889 = Miscellaneous dialysis-other  
 0890 = Other donor bank-general classification; changed to  
 reserved for national assignment (eff 4/94)  
 0891 = Other donor bank-bone; changed to  
 reserved for national assignment (eff 4/94)  
 0892 = Other donor bank-organ (other than kidney); changed  
 to reserved for national assignment (eff 4/94)  
 0893 = Other donor bank-skin; changed to  
 reserved for national assignment (eff 4/94)

0899 = Other donor bank-other; changed to reserved for national assignment (eff 4/94)  
0900 = Psychiatric/psychological treatments-general classification  
0901 = Psychiatric/psychological treatments-electroshock treatment  
0902 = Psychiatric/psychological treatments-milieu therapy  
0903 = Psychiatric/psychological treatments-play therapy  
0904 = Psychiatric/psychological treatments-activity therapy (eff 4/94)  
0909 = Psychiatric/psychological treatments-other  
0910 = Psychiatric/psychological services-general classification  
0911 = Psychiatric/psychological services-rehabilitation  
0912 = Psychiatric/psychological services-day care-redefined 10/97 to less Intensive  
0913 = Psychiatric/psychological services-night care redefined 10/97 to Intensive  
0914 = Psychiatric/psychological services-individual therapy  
0915 = Psychiatric/psychological services-group therapy  
0916 = Psychiatric/psychological services-family therapy  
0917 = Psychiatric/psychological services-biofeedback  
0918 = Psychiatric/psychological services-testing  
0919 = Psychiatric/psychological services-other  
0920 = Other diagnostic services-general classification  
0921 = Other diagnostic services-peripheral vascular lab  
0922 = Other diagnostic services-electromyogram  
0923 = Other diagnostic services-pap smear  
0924 = Other diagnostic services-allergy test  
0925 = Other diagnostic services-pregnancy test  
0929 = Other diagnostic services-other  
0940 = Other therapeutic services-general classification  
0941 = Other therapeutic services-recreational therapy  
0942 = Other therapeutic services-education/training (include diabetes diet training)  
0943 = Other therapeutic services-cardiac rehabilitation  
0944 = Other therapeutic services-drug rehabilitation  
0945 = Other therapeutic services-alcohol rehabilitation  
0946 = Other therapeutic services-routine complex medical equipment

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0947 = Other therapeutic services-ancillary complex medical equipment (eff 3/92)  
0949 = Other therapeutic services-other  
0951 = Professional Fees-athletic training  
0952 = Professional Fees-kinesiotherapy  
0960 = Professional fees-general classification  
0961 = Professional fees-psychiatric  
0962 = Professional fees-ophthalmology  
0963 = Professional fees-anesthesiologist (MD)  
0964 = Professional fees-anesthetist (CRNA)  
0969 = Professional fees-other

0971 = Professional fees-laboratory  
0972 = Professional fees-radiology diagnostic  
0973 = Professional fees-radiology therapeutic  
0974 = Professional fees-nuclear medicine  
0975 = Professional fees-operating room  
0976 = Professional fees-respiratory therapy  
0977 = Professional fees-physical therapy  
0978 = Professional fees-occupational therapy  
0979 = Professional fees-speech pathology  
0981 = Professional fees-emergency room  
0982 = Professional fees-outpatient services  
0983 = Professional fees-clinic  
0984 = Professional fees-medical social services  
0985 = Professional fees-EKG  
0986 = Professional fees-EEG  
0987 = Professional fees-hospital visit  
0988 = Professional fees-consultation  
0989 = Professional fees-private duty nurse  
0990 = Patient convenience items-general classification  
0991 = Patient convenience items-cafeteria/guest tray  
0992 = Patient convenience items-private linen service  
0993 = Patient convenience items-telephone/telegraph  
0994 = Patient convenience items-tv/radio  
0995 = Patient convenience items-nonpatient room rentals  
0996 = Patient convenience items-late discharge charge  
0997 = Patient convenience items-admission kits  
0998 = Patient convenience items-beauty shop/barber  
0999 = Patient convenience items-other

NOTE: Following Revenue Codes reported  
for NHCMQ (RUGS) demo claims effective  
2/96.

9000 = RUGS-no MDS assessment available  
9001 = Reduced physical functions-  
RUGS PA1/ADL index of 4-5  
9002 = Reduced physical functions-  
RUGS PA2/ADL index of 4-5  
9003 = Reduced physical functions-  
RUGS PB1/ADL index of 6-8  
9004 = Reduced physical functions-  
RUGS PB2/ADL index of 6-8  
9005 = Reduced physical functions-  
RUGS PC1/ADL index of 9-10  
9006 = Reduced physical functions-  
RUGS PC2/ADL index of 9-10  
9007 = Reduced physical functions-

Revenue Center Table  
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RUGS PD1/ADL index of 11-15  
9008 = Reduced physical functions-  
RUGS PD2/ADL index of 11-15  
9009 = Reduced physical functions-  
RUGS PE1/ADL index of 16-18  
9010 = Reduced physical functions-  
RUGS PE2/ADL index of 16-18  
9011 = Behavior only problems-

RUGS BA1/ADL index of 4-5  
9012 = Behavior only problems-  
RUGS BA2/ADL index of 4-5  
9013 = Behavior only problems-  
RUGS BB1/ADL index of 6-10  
9014 = Behavior only problems-  
RUGS BB2/ADL index of 6-10  
9015 = Impaired cognition-  
RUGS IA1/ADL index of 4-5  
9016 = Impaired cognition-  
RUGS IA2/ADL index of 4-5  
9017 = Impaired cognition-  
RUGS IB1/ADL index of 6-10  
9018 = Impaired cognition-  
RUGS IB2/ADL index of 6-10  
9019 = Clinically complex-  
RUGS CA1/ADL index of 4-5  
9020 = Clinically complex-  
RUGS CA2/ADL index of 4-5d  
9021 = Clinically complex-  
RUGS CB1/ADL index of 6-10  
9022 = Clinically complex-  
RUGS CB2/ADL index of 6-10d  
9023 = Clinically complex-  
RUGS CC1/ADL index of 11-16  
9024 = Clinically complex-  
RUGS CC2/ADL index of 11-16d  
9025 = Clinically complex-  
RUGS CD1/ADL index of 17-18  
9026 = Clinically complex-  
RUGS CD2/ADL index of 17-18d  
9027 = Special care-  
RUGS SSA/ADL index of 7-13  
9028 = Special care-  
RUGS SSB/ADL index of 14-16  
9029 = Special care-  
RUGS SSC/ADL index of 17-18  
9030 = Extensive services-  
RUGS SE1/1 procedure  
9031 = Extensive services-  
RUGS SE2/2 procedures  
9032 = Extensive services-  
RUGS SE3/3 procedures  
9033 = Low rehabilitation-  
RUGS RLA/ADL index of 4-11  
9034 = Low rehabilitation-  
RUGS RLB/ADL index of 12-18  
9035 = Medium rehabilitation-  
RUGS RMA/ADL index of 4-7  
9036 = Medium rehabilitation-  
RUGS RMB/ADL index of 8-15  
9037 = Medium rehabilitation-  
RUGS RMC/ADL index of 16-18  
9038 = High rehabilitation-  
RUGS RHA/ADL index of 4-7

9039 = High rehabilitation-  
RUGS RHB/ADL index of 8-11  
9040 = High rehabilitation-  
RUGS RHC/ADL index of 12-14  
9041 = High rehabilitation-  
RUGS RHD/ADL index of 15-18  
9042 = Very high rehabilitation-  
RUGS RVA/ADL index of 4-7  
9043 = Very high rehabilitation-  
RUGS RVB/ADL index of 8-13  
9044 = Very high rehabilitation-  
RUGS RVC/ADL index of 14-18

\*\*\*Changes effective for providers entering\*\*\*  
\*\*RUGS Demo Phase III as of 1/1/97 or later\*\*

9019 = Clinically complex-  
RUGS CA1/ADL index of 11  
9020 = Clinically complex-  
RUGS CA2/ADL index of 11D  
9021 = Clinically complex-  
RUGS CB1/ADL index of 12-16  
9022 = Clinically complex-  
RUGS CB2/ADL index of 12-16D  
9023 = Clinically complex-  
RUGS CC1/ADL index of 17-18  
9024 = Clinically complex-  
RUGS CC2/ADL index of 17-18D  
9025 = Special care-  
RUGS SSA/ADL index of 14  
9026 = Special care-  
RUGS SSB/ADL index of 15-16  
9027 = Special care-  
RUGS SSC/ADL index of 17-18  
9028 = Extensive services-  
RUGS SE1/ADL index 7-18/1 procedure  
9029 = Extensive services-  
RUGS SE2/ADL index 7-18/2 procedures  
9030 = Extensive services-  
RUGS SE3/ADL index 7-18/3 procedures  
9031 = Low rehabilitation-  
RUGS RLA/ADL index of 4-13  
9032 = Low rehabilitation-  
RUGS RLB/ADL index of 14-18  
9033 = Medium rehabilitation-  
RUGS RMA/ADL index of 4-7  
9034 = Medium rehabilitation-  
RUGS RMB/ADL index of 8-14  
9035 = Medium rehabilitation-  
RUGS RMC/ADL index of 15-18  
9036 = High rehabilitation-  
RUGS RHA/ADL index of 4-7  
9037 = High rehabilitation-

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RUGS RHB/ADL index of 8-12  
9038 = High rehabilitation-

RUGS RHC/ADL index of 13-18  
9039 = Very High rehabilitation-  
          RUGS RVA/ADL index of 4-8  
9040 = Very high rehabilitation-  
          RUGS RVB/ADL index of 9-15  
9041 = Very high rehabilitation-  
          RUGS RVC/ADL index of 16  
9042 = Very high rehabilitation-  
          RUGS RUA/ADL index of 4-8  
9043 = Very high rehabilitation-  
          RUGS RUB/ADL index of 9-15  
9044 = Ultra high rehabilitation-  
          RUGS RUC/ADL index of 16-18